

Medical Economics

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Medical Economics

NEWS BRIEFS

ONE OF THE BIGGEST AWARDS EVER MADE for a "staph" infection has been handed down by a Memphis jury. It ordered the Methodist Hospital to pay \$25,000 to a couple who contracted "staph" from their newborn child. No doctors were defendants in the suit.

IT'S CHEAPER TO PHONE: According to a Chicago research firm, the average cost of sending an average business letter is now \$1.83.

M.D.s AND ATTORNEYS HAVE ADOPTED a new fee schedule for medical services in legal cases in San Mateo County, Calif. Sample items include \$10 for writing a 1-page letter or short report, \$25 for a standard medical report, \$35 for a 1-hour pretrial conference, and \$75 for a brief appearance in court.

FUND-RAISING FROST: Charity givers in Miami, Fla., who'd been told their United Fund had gone over the top in its '58 and '59 drives, learned recently that it did so only by borrowing some \$700,000.

NEWS BRIEFS

DEAL AN INSURER OFFERED DOCTORS has been ruled unethical by the New Jersey medical society. The insurer promised doctors a fee for every expectant couple they talked into buying an insurance policy against their baby's being born malformed.

DOCTORS ARE FIGHTING FOR REPEAL of a new Nebraska State Board of Health regulation that 2 physicians must be in attendance and scrubbed whenever major surgery is performed. Doctors maintain that the rule, which is scheduled to take effect July 1, will needlessly increase the cost of some surgery.

EVEN IF CONGRESS DOESN'T INCLUDE M.D.s under Social Security this year, there's one way some can get coverage. An Oregon doctor who planned to retire sold his practice to a younger man, then worked for a time as his employe. Social Security taxes were withheld from his salary. After the older man's death, his widow applied for Social Security benefits. Now a Federal Court has upheld her claim.

DOCTORS MUST ACCOUNT IN DETAIL to the I.R.S. for any travel- or entertainment-expense deductions they claim for 1960. A new ruling also requires that all self-employed doctors netting \$10,000 or more report in detail not only their own travel expenses, but also those of any employees (such as salaried associates) earning \$10,000 or more.

WHAT PERCENTAGE OF SPECIALISTS include their specialty in their classified telephone listing? A new study by this magazine shows that about 80% do.

D.O.s HAVE GAINED A ROUND in their fight for equal status with M.D.s. The new health insurance program for Federal employes stipulates that Blue Shield must pay D.O.s. Under the program, even those Blue Shield plans that are forbidden by state law to pay osteopaths must now find some way to see that Government workers are reimbursed for fees paid to any D.O. "legally qualified and licensed to practice medicine and surgery."

6,000 MALPRACTICE SUITS were filed in the U.S. last year, Pennsylvania Lawyer A. H. Clephane estimates. He puts their total cost, including attorneys' fees, settlements, judgments, etc., at about \$50,000,000.

LAST-DITCH BATTLE against compulsory government-controlled health care is being waged by doctors in Canada's Saskatchewan Province. Premier T. C. Douglas, who proposed the scheme, has scheduled an election on the issue for next month; he says his government will stand or fall on what the voters decide. Meanwhile, the Saskatchewan College of Physicians and Surgeons has assessed members \$100 apiece for a war fund and has asked the Canadian Medical Association for financial aid.

NEWS BRIEFS

VISITING BRITAIN THIS SUMMER? The British Medical Assn. has set up an International Medical Advisory Bureau to help you find accommodations, arrange visits to hospitals and clinics, etc. Its address is Tavistock Square, London, W.C. 1, England.

MEDICINE GOT A BLACK EYE in Fairfield County, Connecticut, recently, when a collection agency dunned a patient for 50% more than he owed a doctor. The patient complained to the county medical society. Now Fairfield County doctors are considering setting up their own collection agency.

IT'S LEGALLY RISKY for medical societies to set or even recommend setting standard fees for life insurance examinations, the A.M.A.'s law division has warned. Since most insurers are in interstate commerce, the A.M.A. says, M.D.-groups that agree on standard fees to charge insurers risk prosecution for restraint of trade under the Sherman Act. This could bring on both civil and criminal suits.

DOCTORS ARE UP IN ARMS in New York because the Albany Blue Cross is now paying for out-patient diagnostic work—including radiology—done in hospital out-patient departments. The plan says this coverage helps cut down needless hospitalization. But radiologists say it puts Blue Cross in direct competition with private practitioners.

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Medical Economics

INDEPENDENT NATIONAL BUSINESS MAGAZINE FOR PHYSICIANS, MAY 9, 1960

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How We Formed a Part-Time Partnership 69

Do you wish you could combine the satisfaction of solo practice with the less hectic pace of partnership? Consider the combination worked out by these two doctors

'Cheap' Health Insurance Robs You and Patients . . . 74

From home offices in states with lax insurance laws, certain companies can flood the nation with shockingly inadequate policies. How can you do your bit to stop them?

Can a Doctor Afford to Be Controversial? 80

This physician played a leading role in a nonmedical battle that divided his community. Here he weighs the cost

Best Performers Among the Mutual Funds 84

Are the funds doing the kind of job they're supposed to do? Which ones are beating the market in general, which lagging behind? This objective analysis of forty-eight leading funds gives you a helpful basis for comparison

More►

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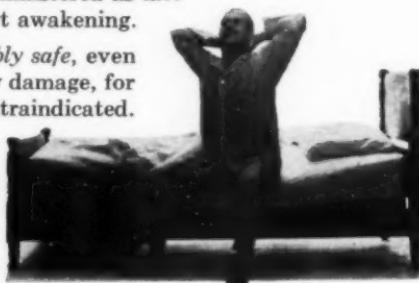
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A doctor who bought his first horseless carriage in 1908 recalls the thrills of those early gas-driven days. You may find yourself wishing you'd been there to cheer him on

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This experienced internist has some pertinent things to say about what constitutes good manners on both ends of the referral situation. Would you pass his test?

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If they just can't bear waiting their turn, or if they just can't stop talking, why not have special times for seeing them? It pays off for you, for them, for your staff, and for your other patients, says this doctor who's tried it ***More►***



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A Century
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to Medicine

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Certifying Board for G.P.s? It's Sure to Come 213

An unofficial American Board of General Practice has been set up. And although the A.A.G.P. has voted to censure its founders, the door is still open. Here's a first-hand report on the latest moves toward G.P. certification

BOOK FEATURE

Spotlight on Senator Kennedy 245

When his publishers asked him to write a biography of Senator Kennedy, James MacGregor Burns had misgivings. Not unless it could be 'as honest a study . . . as if he were a dead statesman,' Burns stipulated. Given free access to Senator Kennedy's files, he went ahead. He describes the result—the best-selling book 'John Kennedy: A Political Profile'—as 'an attempt to supply needed information, a measure of analysis, and a few judgments on one of the best-known and least-understood of American political leaders.' A selection from it appears in these pages **More ▶**



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Letters

On Small-Town Practice

Writing under the pen name Brennann Donnavae, a G.P. from a place he called "Feckless" recently wrote a MEDICAL ECONOMICS article entitled "Small-Town Practice? You Can Have It!" In his rural community, he said, patients are demanding, ungrateful, and slow paying; he portrayed Feckless as a clan-ridden, gossip-infested nightmare. Readers have responded to the article with considerable heat. The following letters are representative of the many received.—ED.

SIRS: Three cheers for Dr. Donnavae for telling the truth! To practice medicine in a small town and keep everyone satisfied, a physician needs the diagnostic ability of Sir William Osler, the combined medical skills of the staff of the Mayo Clinic, the finesse of Franklin D. Roosevelt, and the forbearance of the Almighty.

J. H. Barnebee, M.D.
Corsicana, Tex.

SIRS: . . . I agree with every word of the article. Some patients even bring their injured animals to me for treatment. I don't mind, really.

But it does make me wonder where a doctor fits into the small-town scheme of things.

Walter D. Cason, M.D.
Gold Beach, Ore.

SIRS: . . . The article is an insult to small-town practitioners. Would the author be any more successful if his office were in the middle of Times Square? I doubt it!

Donald V. Malick, M.D.
Hegins, Pa.

SIRS: . . . Stay away from the big cities, Dr. Donnavae. Pick out another rural community, preferably a little bigger than Feckless. Get a partner. And persuade the community to build and run your hospital for you. The people will appreciate it more because it's theirs. And if you can't find what you're looking for, there's an opening in my clinic for a good man.

Richard M. Rogers, M.D.
Whitehall, Wis.

SIRS: . . . When I practiced in a small rural area many years ago, I often overheard this remark: "If the doctor were any good, he wouldn't be out here in the sticks in the first place." This kind of

Letters

thing sent me to the city—where I stayed until I retired.

Rollin M. Falk, M.D.
Mapleton, Ore.

SIRS: . . . The plain truth is that a town like Feckless probably can't support a well-trained G.P. Such a town doesn't really want a doctor —just an adequately-schooled first- aider. But let's hope young men looking forward to small-town practice won't take Dr. Donnave too seriously. Not every small town is like Feckless.

Rodman Cary Jacobi, M.D.
Oxford, Mich.

SIRS: . . . Dr. Donnave paints an unnecessarily black picture of small-town practice. An article of this sort does incalculable harm to the many small towns that can support and do need a doctor. In fact, it's dangerous and harmful to generalize from one such case.

Feckless isn't representative of the small towns that come to the Sears-Roebuck Foundation for help in locating a doctor. Rural communities today rarely offer old mansions, offices above a bank, or converted stores as medical facilities. Many build medical centers with features that are equal to those found in any big city. Rural

America knows perfectly well that, if it's going to have major-league medicine, it must provide major-league facilities.

There is need for medical care in small towns. It's often a critical need. These small towns are "politically potent." So if you don't want Uncle Sam to point a finger at organized medicine, don't sell rural America short.

Norman H. Davis
Secretary
Medical Advisory Board
The Sears-Roebuck Foundation
Chicago, Ill.

A Lawyer on Lawyers

SIRS: A recent article urges the doctor to report potential malpractice claims promptly to his insurance carrier. That's good preventive legal medicine, of course. But the doctor will do well to remember that insurance company agents, claims men, adjusters, and attorneys represent the *company*.

If a doctor is sued in excess of his policy limits, or if some difficulty arises as to coverage under the policy, the doctor should consult his own lawyer. The lawyer will represent *him*.

Theodore M. Bailey
Attorney
Sioux Falls, S.D.

Family Spending

SIRS: The implication in Dr. John J. Meiklejohn's article "Unbal-
Continued on page 22

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*88 calories in a medium banana — USDA Handbook No. 8, *Composition of Foods*.

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002207

Letters

anced by a Budget" is that no doctor earning \$18,000 per year can make a domestic budget work. All his figuring seems to prove only one thing: Dr. Meiklejohn needs \$1,000 more per year than he now earns.

But does he? Does his wife really need a full-time maid? Does his son really have to attend a private school? And does Dr. Meiklejohn himself need to go quail-hunting at a cost of \$60 per bird?

He should have asked himself

such questions before foolishly tossing his "unworkable" budget out the window.

Paul F. Maddox, M.D.
Campton, Ky.

SIRS: . . . Good for Dr. Meiklejohn! Too much saving for a rainy day is the surest way to guarantee that there'll be a rainy day. If everybody were to adhere to a strict budget, what would become of the market for our gleaming but not always useful products? Too much thrift would cause factories to grind to a halt, unemployment to skyrocket. Dr. Meiklejohn is not only free of a stultifying budget;

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"To those patients who had multiple metastases and metastatic lesions, Tigan was truly a godsend, enabling them to continue treatments and obtain relief . . . not obtainable in any other non-surgical way."¹ Successful in some of the most challenging conditions, such as radiation^{1,2} or nitrogen mustard therapy,³⁻⁵ Tigan is equally effective in all other situations calling for the prevention or control of nausea and vomiting. Travel sickness, pregnancy and gastrointestinal disorders are among the leading indications for Tigan. Three convenient forms: Tigan Capsules—100 mg, blue and white • Tigan Ampuls—2 cc (100 mg/cc) • Tigan Suppositories—200 mg.

*no special precautions
no known contraindications*

Tigan

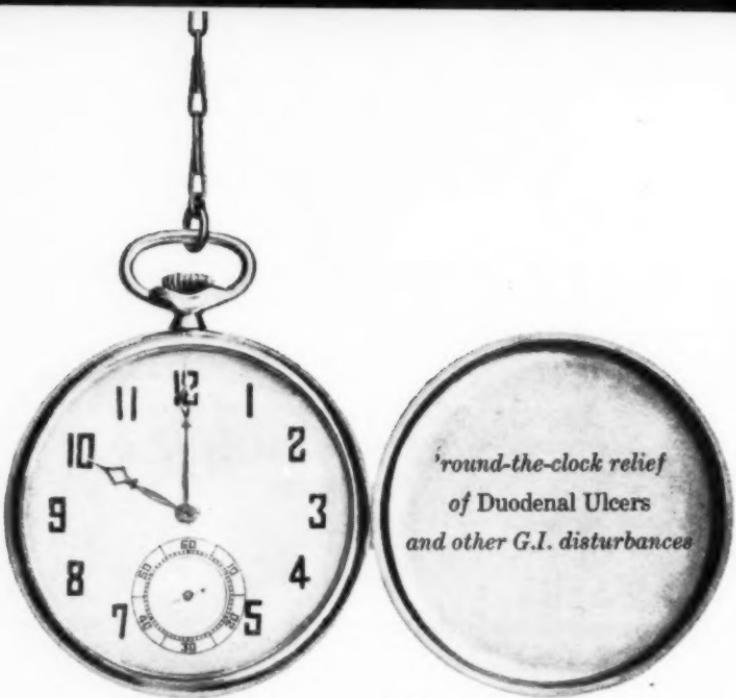
safely controls the entire range of emetic situations

References: 1. J. A. Lucinian and R. H. Bohn, paper read at Colloquium on The Pharmacological and Clinical Aspects of Tigan, New York City, May 15, 1959. 2. H. E. Davis, Discussant, *ibid.* 3. W. B. Abrams, I. Roseff, J. Kaufman, L. M. Goldman and A. Bernstein, *New York J. Med.*, 59:4217, 1959. 4. I. Roseff, W. B. Abrams, J. Kaufman, L. Goldman and A. Bernstein, *J. Newark Beth Israel Hosp.*, 9:189, 1958. 5. B. I. Shnider and G. L. Gold, paper read at Colloquium on The Pharmacological and Clinical Aspects of Tigan, New York City, May 15, 1959. 6. M. W. Goldberg, *ibid.* 7. O. C. Brandmann, *ibid.* 8. D. W. Molander, *ibid.* 9. W. S. Derrick, *ibid.* 10. B. Wolfson and F. F. Foldes, *ibid.* 11. W. K. Gauthier, Discussant, *ibid.* 12. L. McLaughlin, *ibid.* 13. W. Schallek, G. A. Heise, E. F. Keith and R. E. Bagdon, *J. Pharmacol. & Exper. Therap.*, 126:270, 1959. 14. Reports on file, Roche Laboratories. 15. Personal communications.



ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc. Nutley 10, N. J.

TIGAN® Hydrochloride—4-(2-dimethylaminoethoxy)-N-(3,4,5-trimethoxybenzoyl)benzylamine hydrochloride



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oxyphenylcyclimine HCl, 10 mg.

b.i.d.

"Good symptomatic responses were seen in 91 of 96 [patients] treated for periods up to one year with average doses of 10 mg. twice daily." "[Daricon] appears to be a valuable agent... for day-to-day maintenance of all peptic ulcer patients." Winkelstein, A.: Am. J. Gastroenterol. 32:66-70 (July) 1959.

Additional information is available on request from the Medical Department, Pfizer Laboratories, Brooklyn 6, New York.

Pfizer Science for the world's well-being™

he can also take heart in the knowledge that he's contributing to the national prosperity.

Herbert Berger, M.D.
Tottenville, N.Y.

The Limits of Practice

SIRS: One of your correspondents says he's disturbed at having found it necessary to dismiss a hard-to-handle schizophrenic patient.

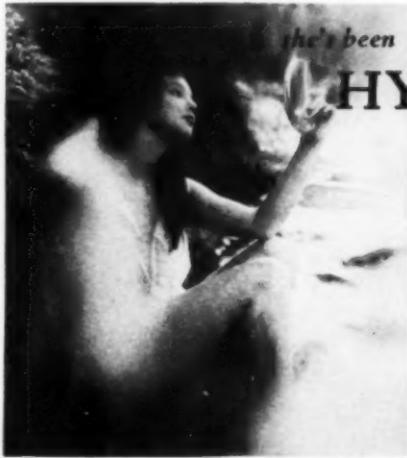
This doctor's attack of conscience makes me wonder to what extent we're expected to be our brothers' keepers. If we carry the torch for all the unfortunates of society (noble as that may be), we'll

Letters

also be exposing ourselves to a good many physical, financial, and legal hazards.

Almost every community has social agencies, police officials, probation officers, welfare bureaus, rehabilitation centers, etc. Let's tap these community resources before we agree to baby-sit every confused, paranoid, suicidal, or anti-social patient who walks in the door.

M.D., West Virginia
END



HYFRECATED*

Desiccate those unsightly, possibly dangerous skin growths with the ever-ready, quick and simple to use Hyfrecator®. More than 150,000 instruments in daily use.

*not a blemish on her



Please send me your new full-color brochure showing step-by-step Hyfrecation techniques.

Doctor _____

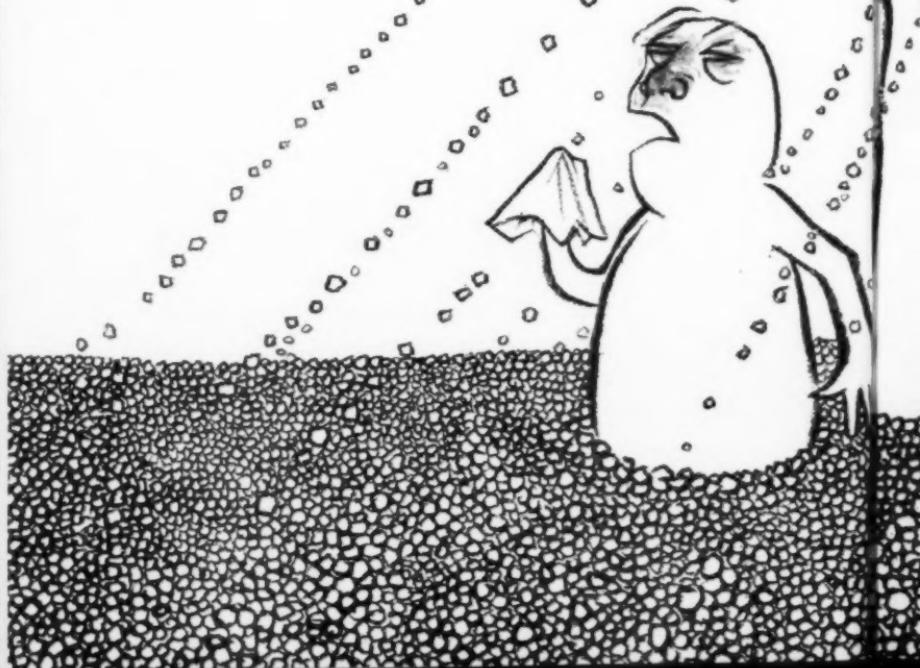
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Polaramine
Repetabs





Schering

answer the question of how to treat the patient allergic to tree pollens. (Birch, hickory and oak are the most important offenders, and oak is the most abundant.) With POLARAMINE REPETABS — today's lowest-dosage antihistamine — you can control rapidly and safely the annoyance and discomfort of seasonal or nonseasonal allergies, allergic dermatoses, allergic complications of respiratory illnesses, and drug and serum reactions.

Histamine is present in most tissues of the body, but it is concentrated in those body areas exposed to contact with the external environment: the skin, the respiratory tree, and the upper gastrointestinal tract. When an antigen, whether from tree pollen or any other allergenic substance, provokes an antibody response, histamine is released, and the familiar symptoms of allergy follow. POLARAMINE —in any form—controls these allergic reactions by blocking the access of histamine to receptor sites, and POLARAMINE does this at dosages lower than those necessary with other available antihistamines.

POLARAMINE REPETABS (4 mg. and 6 mg. dosage forms for your patients' convenience) and POLARAMINE Tablets (2 mg.) are unrivaled in effectiveness and safety. The rapidity of action for which POLARAMINE is noted is also important to the physician. Summarizing treatment of a recent group of 100 allergic patients, Babcock and Packard report that POLARAMINE REPETABS were "...especially effective in patients who presented sudden, acute allergy symptoms."*

Remember also that POLARAMINE Syrup—it tastes good—is a great help in treating the young allergic patient or those who prefer liquid medication.

Dosage: REPETABS, 6 mg. and 4 mg.—One REPETAB in the morning and one REPETAB in the evening. Tablets, 2 mg.—One t.i.d. or q.i.d.; children under 12, one-half tablet t.i.d. or q.i.d.; infants, one-quarter tablet t.i.d. or q.i.d. Syrup, 2 mg. per 5 cc.—Adults, one teaspoonful t.i.d. or q.i.d.; children under 12, one-half teaspoonful t.i.d. or q.i.d.; infants, one-quarter teaspoonful t.i.d. or q.i.d.

Supply: POLARAMINE REPETABS, 6 mg., bottles of 100 and 1000; 4 mg., bottles of 100 and 1000. Tablets, 2 mg., bottles of 100 and 1000. Syrup, 2 mg. per 5 cc., 16 oz. bottles.

*Babcock, G., Jr., and Packard, L. A.: *Clin. Med.* 6:985 (June) 1959.

POLARAMINE® Maleate, brand of dexchlorpheniramine maleate. REPETABS® Repeat Action Tablets.

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speed
patient
recovery



MI-CEBRIN T®—therapeutic vitamin-mineral tablet helps meet increased nutritional demands

"Primary or secondary nutritional disorders produce or complicate all the problems of the sick."¹ Patients undergoing any prolonged convalescence will recover faster with potent nutritional supplementation.

Mi-Cebrin T supplies therapeutic quantities of vitamins and minerals plus intrinsic factor—the "B₁₂ absorption booster" of special value to those elderly patients whose ability to absorb vitamin B₁₂ may be impaired. For your convalescing patients—prescribe one or more Tablets Mi-Cebrin T a day.

Mi-Cebrin T® (vitamin-minerals therapeutic, Lilly)

1. Spies, T. D.: Some Recent Advances in Nutrition, J.A.M.A., 167:675, 1958.

LILLY VITAMINS . . . "THE PHYSICIAN'S LINE"

506301

News

Publish Doctors' Incomes To Expose Profiteers?

"I believe a doctor should make a better than average living, for most of them work hard hours, but to become wealthy on the ills and hurts of their fellow men cannot be tolerated." This challenge comes from an uneasy Virginia citizen who senses socialized medicine in the offing if the profession's profiteers aren't controlled.

Writing to the editor of the Richmond Times-Dispatch, M. B. Heizer Jr. professes to see only "one way short of socialized medicine that might control those who are giving the whole profession such a black name. We could require anyone using a doctor's license to make public each year his income. This sort of thing is already required of most of our other big-salary men, such as corporation officers [and] government officials . . . So why not doctors?"

'Don't Expect Any Miracles From Collection Agencies'

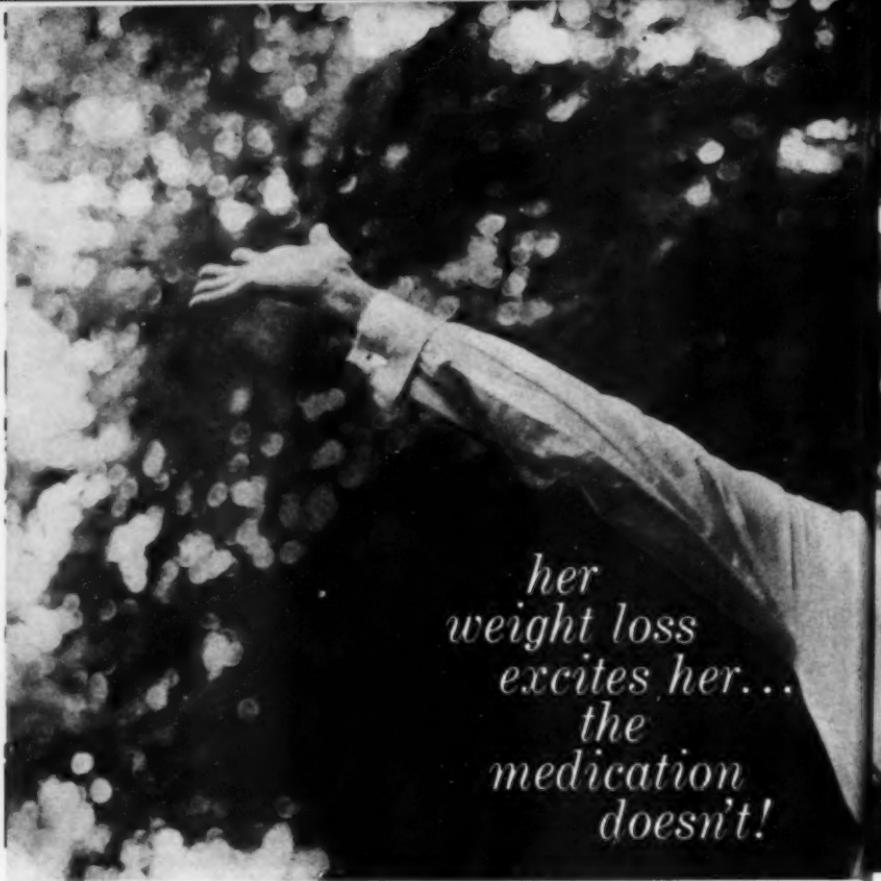
How much return should doctors expect on the delinquent accounts they turn over to collection agencies? One medical group that sent

a large number of such accounts to an agency in the past two years recently totted up the results. The doctors found that they've realized only about ten cents on the dollar.

Burton T. Whitlock, manager of the four-doctor Cody (Wyoming) Clinic, has analyzed what became of 668 delinquent accounts he has turned over to collectors since 1957. On paper, these accounts were worth nearly \$40,000. The agency has collected just over \$8,000 on them. And since the collection fees amounted to 50 per cent of receipts, the doctors ended up with only about \$4,000.

Does this mean it's not worth while to use a collection agency? Not at all, Whitlock says: "For one thing, we worked these accounts thoroughly before they went to the collectors. We sent many letters, made phone calls, and spoke with the nonpayers in person. To do any more would have cost us more than it was worth."

Considering that the collectors got only accounts on which all these methods failed, Whitlock doesn't feel they did a bad job. "The returns may be mediocre



*her
weight loss
excites her...
the
medication
doesn't!*

Late evening dose doesn't interfere with sleep.

Since Tenuate is free of CNS stimulation, it can be given in mid-evening, when TV snacks run up a high calorie count. Doses given to control late evening snacks will not interfere with sleep.³

Tenuate cuts the urge to eat. So well, in fact, that weight loss on Tenuate averages over 1.5 lbs. a week (see chart).

Safe—Tenuate can be used even in overweight cardiacs or hypertensives.

EKG studies substantiate Tenuate's

lack of appreciable CNS stimulation. No effect on heart rate, blood pressure, pulse or respiration is demonstrable.⁴ Thus Tenuate is particularly well suited for hypertensive and cardiac patients—those whose weight must come down.

PROOF OF WEIGHT LOSS³⁻⁴ In a series of 102 patients, the following weight losses were obtained:

Lbs./Week	Number of Patients	% Patients
0.1-0.9	23	22.54
1.0-1.9	51	50.00
2.0-2.9	25	24.52
3.0-4.0	3	2.94
	102 PATIENTS	100%



new
TENUATE
(diethylpropion)
hunger control with
no CNS stimulation

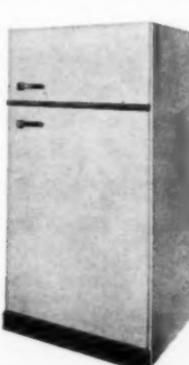
Indications: The overweight patient, including adolescent, geriatric and gravid, as well as special risk situations—cardiac, hypertensive, diabetic.

Dosage: One 25 mg. tablet one hour before meals. To control nighttime hunger, an additional tablet taken in mid-evening will not induce insomnia.

References: 1. Huels, G.: Mich. Acad. Gen. Pract. Symposium, Detroit, 1959. 2. Alvaro, R. D.: personal communication. 3. Spielberg, J. D.: Mich. Acad. Gen. Pract. Symposium, Detroit, 1959. 4. Ravets, E.: Mich. Acad. Gen. Pract. Symposium, Detroit, 1959. 5. Declina, L. and Esposito, A.: personal communication. 6. Alvaro, R. D.: personal communication. 7. Kroots and Storch: personal communication. 8. Alvaro, R. D.; Gracanin, V., and Schleuter, E.: to be published.

TRADEMARK: "TENUATE"

thwarts refrigerator raiders



TENUATE
Especially
for late
evening
snackers.
Controls
hunger
without
producing
sleepless-
ness.



THE WM. S. MERRELL COMPANY
New York • Cincinnati • St. Thomas, Ontario

News

measured against the total value of the accounts," he says. "But they are better than nothing—which is what the doctors probably would have got if they hadn't used the agency."

Put Your Money Where Your Mouth Is, Broker Urges

Which industry promises doctors the best long-range investment possibilities? "Not plastics, not electronics, not space travel," declares one stock market analyst. "The great industry of the 1965-75 decade and thereafter is 'chatter.'"

Right now most "chattering" is done on long-distance telephones by men talking business, explains Analyst Walter K. Gutman of Shields & Co., a brokerage house. But in the next few years, new techniques of phoning by microwave will become cheaper. It may even become possible to talk cross-country for the same ten cents it now costs to make most local calls. By then, long-distance phones will be used as much by women as by men.

When that happens, there'll be "a real explosion of chatter . . . You're going to see a boom in chatter [as big as] there was when women took to cigarettes," predicts Gutman. That's why chatter

"is going to become the greatest of all businesses in the next twenty years."

How can doctor-investors cash in on this business growth? Gutman advises them to keep an eye on these four stocks:

1. American Telephone & Telegraph—the "giant." "Under certain circumstances, the growth in net per share for [this company] could become extremely rapid . . . There are possibilities in the stock not only of moderate capital gains to be made with great safety but of very large capital gains to be made with safety. You don't often get this sort of combination."

2. General Telephone—the "teen-ager," only one-twentieth as big as A.T.&T. "Since this company is very vigorously managed, I would keep it if I had it as a long-term holding," Gutman says.

3. United Utilities—the "pigmy." "At present prices, there is a possibility of a quick 25 to 30 per cent gain which isn't visible" in other telephone stocks.

4. Western Union. At present, this company isn't equipped to take advantage of the coming boom in "female chatter," says Gutman. But he points out that it would be so equipped if a rumored merger with one of the telephone companies went through. His analysis: "On a speculative basis, I

Continued on page 38

Upjohn

The Upjohn Company, Kalamazoo, Michigan

48-hour result in acute contact dermatitis

a)
Severe
poison ivy
dermatitis
of face



b)
24 hours
after a
single 2 cc.
(80 mg.)
injection of
Depo-Medrol



c)
48 hours
after
Depo-Medrol
therapy



Photographs courtesy of
Earl B. Brown, M.D.

Even in severe, disabling cases of acute contact dermatitis, Medrol usually elicits prompt response. The duration of treatment is brief, rarely needing to extend beyond a few days.

**there is only one
methylprednisolone,
and that is**

Medrol*

**the corticosteroid
that hits the disease,
but spares the patient**



Medrol is supplied as 4 mg. tablets in bottles of 30, 100 and 500; as 2 mg. tablets in bottles of 30 and 100; and as 16 mg. tablets in bottles of 50. Depo-Medrol** is supplied as 40 mg. per cc. injectable suspension in 1 cc. and 5 cc. vials.

*Trademark, Reg. U. S. Pat. Off.—methylprednisolone, Upjohn **Trademark

here are some of the ways hypertensive patients benefit when you prescribe **DIUPRES**

greater antihypertensive effect

fewer side effects

rapid onset of
antihypertensive effect

anxiety and tension
are allayed

convenient,
controlled dosage

dietary salt
may be liberalized

such symptoms
as headache,
dizziness,
palpitations and
tachycardia
are usually
relieved . . .
anginal
pain may be
reduced in
incidence
and severity

organic
changes of
hypertension
may be
arrested
or reversed

edema
associated with
hypertension
is
relieved

the first "wide range" antihypertensive

DIUPRES

DIURIL WITH RESERPINE

effective by itself in a majority of patients with mild or moderate hypertension, and even in many with severe hypertension . . . should other drugs need to be added, they can be given in much lower than usual dosage.

DIUPRES-250

250 mg. DIURIL (chlorothiazide),
0.125 mg. reserpine per tablet.
One tablet one to four times a day.

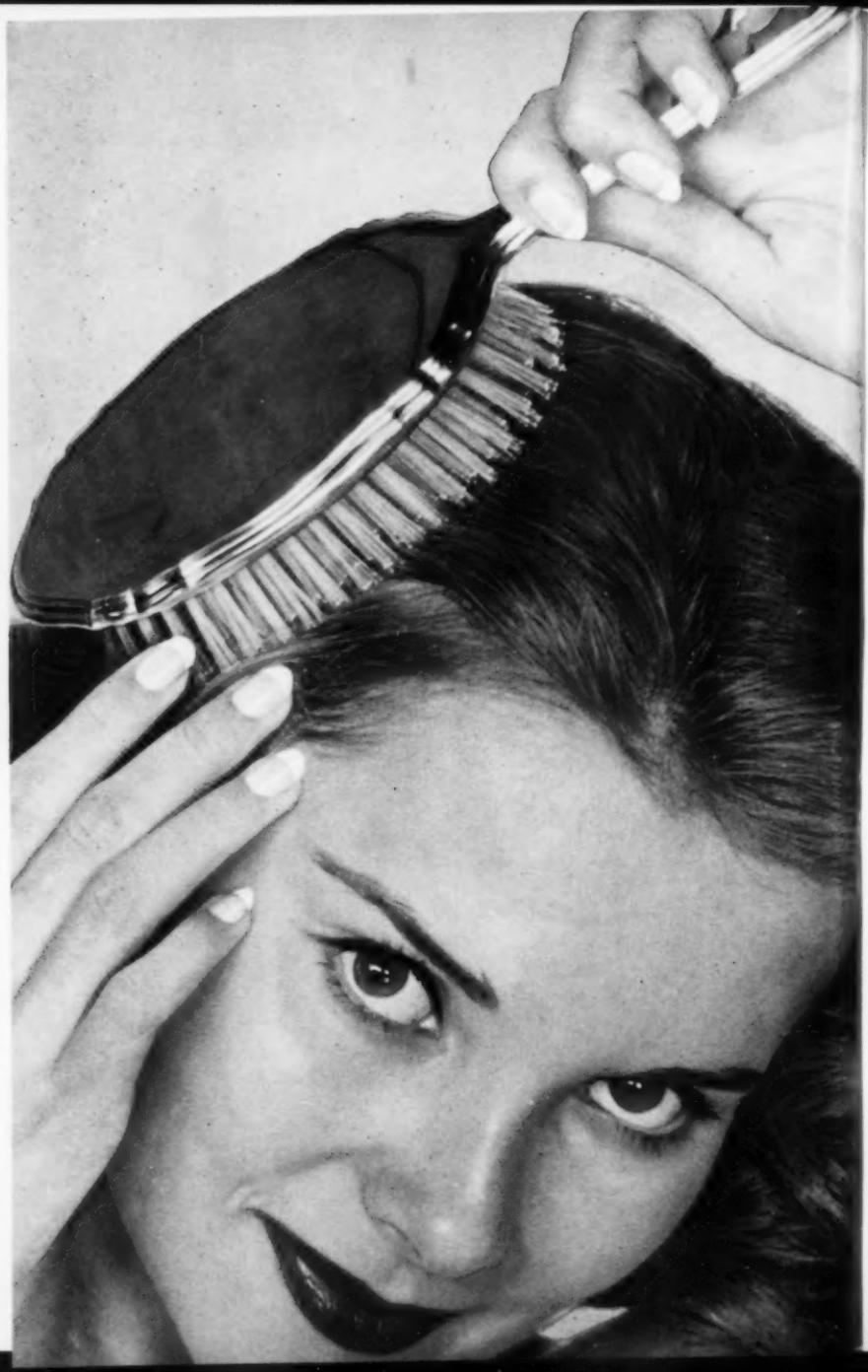
DIUPRES-500

500 mg. DIURIL (chlorothiazide),
0.125 mg. reserpine per tablet.
One tablet one to three times a day.

For additional information, write Professional Services, Merck Sharp & Dohme, West Point, Pa.
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XUM

patient goal:

beautiful fingernails

physician Rx:

Knox Gelatine

Brittle fingernails are a real source of distress to women so afflicted. That's why it's important to be able to provide more than psychological support for such patients.

Knox Gelatine restores normal nail strength in approximately 80 per cent of patients with brittle laminating fingernails. This fact has been confirmed by four independent clinical studies involving 122 subjects. Dosage is one to 3 envelopes of Knox Gelatine per day and improvement usually begins within 30 days.

One point needs special emphasis. Research has established that the entire envelope of Knox Gelatine (120 grains) must be taken in a single dose to provide the dynamic effects necessary to correct the brittle nail defect. Advise your patients against fractional or divided doses. If you would like to examine the substantiating studies just use the coupon below.



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please send reprints of the following articles:

- 1. Rosenberg, S., Oster, K.A., Kallos, A. and Burroughs, W.: A.M.A. Arch. Dermat. 76:330, September 1957.
- 2. Schwimmer, M. and Mulinos, M.G.: Antibiot. Med. & Clin. Therapy 4:403, July 1957.
- 3. Rosenberg, S. and Oster, K.A.: Conn. State Med. J. 19:171, March 1955.
- 4. Tyson, T.L.: J. Invest. Dermat. 14:323, May 1950.

Your Name and Address

News

like Western Union . . . The stock has acted very well in the weak markets we have had."

Malpractice Premiums Cut By One Big Insurer

Malpractice insurance rates have been rising almost everywhere. But now one of the largest professional liability underwriters has announced that it'll slice premiums for many doctors. The Medical Protective Company of Fort Wayne, Ind., will cut rates for (1) M.D.s who are in partnerships of fewer than five and (2) M.D.s in some states who perform no major surgery. The two reductions will be figured this way:

Doctors who are in partnerships of fewer than five won't have to buy the "extra policy" that they've been required to carry in the past. Instead, they'll pay for one policy for each partner, plus an additional 20 per cent of this total. To illustrate:

Suppose two Kansas doctors paid \$192 for \$50/150,000 coverage under the old plan. Now they'll pay \$153.60, receiving a reduction of \$38.40.

The company's second reduction will go to physicians who perform no major surgery. This lower premium will be based on the loss ex-

periences of each of the seventeen states the company covers. The few states with high loss experiences won't get a cut; their premiums will remain the same.

How has this company been able to offer these cuts when other companies' premiums have tended to move upward? It's apparently because the incidence of suits against doctors it insures hasn't increased significantly in recent years.

More Federal Benefits? 'I Can't Afford Them!'

"Next guy comes along and says he's going to make my old age easier, my medical expenses lighter, or my 'social benefits' greater is going to run into my own, private, hot-headed revolution," declares one newspaper's business and financial editor. "I will vote against and militate against any [candidate] who promises to improve my lot. I've been improved all I want to be and, by golly, my lot can't afford any further improvement."

It's necessary to bring up this point, continues Donald I. Rogers of the New York Herald Tribune, because in this election year "Congress is afflicted with its historical itch to grant us some more 'benefits' . . . The biggest thing in the give-away arena these days" is the Forand bill.

"On the surface it sounds like a most humanitarian piece of legisla-

*Treatment
for the
sinus symptom
complex*

works from the inside out

URSINUS™

Calurin® plus Triaminic®

In acute and chronic sinusitis



... a logical, clinically superior formulation of

Calurin . . . the new, freely soluble,
better tolerated *neutral salt* of aspirin

relieves pain . . . fast and effectively



Triaminic . . . the leading oral
nasal decongestant . . . safer and more
effective than topical medication^{1,2}

relieves pressure . . . within minutes

Ursinus Inlay-Tabs™ contain:

CALURIN (5 gr.) 300 mg.

TRIAMINIC 50 mg.

INDICATIONS: Acute, subacute and chronic sinusitis.
Relief of symptoms accompanying the common cold.

DOSAGE: Adult: 1 or 2 URSINUS Inlay-Tabs every
4 to 6 hours. Children 6 to 12: $\frac{1}{2}$ to 1 URSINUS
Inlay-Tab every 6 hours.

SUPPLY: Bottles of 100 URSINUS Inlay-Tabs.

URSINUS is available on prescription only.

SMITH-DORSEY • Lincoln, Nebraska
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1. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958.
2. Lhotka, F. M.: Illinois M. J. 112:259 (Dec.) 1957.

News

tion and one which every warm-hearted American slob would want to have his Congressman vote for," Rogers writes. But "get down to hard facts and the program is hard to justify.

"Surveys have shown that most older people have money or insurance to cover their medical expenses. Other figures show that medical insurance for the elderly is being more widely purchased all the time."

What's more, adds Rogers, "liabilities of the Federal Social Security system now total \$361 billion —of which \$340 billion must be raised by future taxes . . . If only porkbarrelers like Forand and others of his stripe would let this one election pass without burdening us with further such 'benefits,' we might [still] be able to make it as a solvent nation in spite of our lovable lawmakers."

Resident Matching Program Can't Be Made to Work

What has happened to that proposed national matching program for residents—the one that was supposed to do for them what the National Intern Matching Program has done for internes? Here's the answer from the man in the best position to know:

"I don't see how it can be made to work," says Dr. Ward Darley, executive secretary of the N.I.M.P. He explains his pessimism this way:

Interne matching works because it deals with a homogeneous group. They all graduate and start similar internships at the same time. Besides, they are all concentrated in about eighty schools where they can be contacted easily. But residents diverge in their educational aims through more than twenty different types of residencies, and they don't all start their residencies at the same time of year. Then, too, the residency candidates are scattered among more than 800 hospitals, making communications difficult.

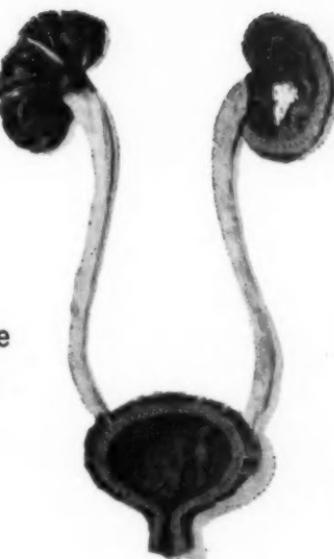
This alone would create technical problems in setting up a matching program for residents, says Dr. Darley. But there's also the matter of dealing with so many more residents than internes.

For instance, each of the current 7,000 senior medical students has listed perhaps four or five choices of hospital. Matching them with 12,800 internships requires constant rechecking to prevent something from going wrong.

A program for residents would be even more complex. There are about 13,000 new residency vacancies and about 11,000 new residents appointed every year.

Continued on page 44

Just a "simple" case of cystitis may be the precursor of pyelonephritis¹—or may actually be the first evidence of a pre-existing pyelonephritic process.²



WHEN TREATING CYSTITIS—SPECIFY

FURADANTIN®

brand of nitrofurantoin

to ensure rapid control of infection

FIRST

throughout the urogenital system

Rapid bactericidal action against a wide range of gram-positive and gram-negative bacteria including organisms such as staphylococci, Proteus and certain strains of Pseudomonas, resistant to other agents ■ actively excreted by the tubule cells in addition to glomerular filtration ■ negligible development of bacterial resistance after 8 years of extensive clinical use ■ excellent tolerance—nontoxic to kidneys, liver and blood-forming organs ■ safe for long-term administration

AVERAGE FURADANTIN ADULT DOSAGE: 100 mg. q.i.d. with meals and with food or milk on retiring. Supplied: Tablets, 50 and 100 mg.; Oral Suspension, 25 mg. per 5 cc. tsp.

REFERENCES: 1. Campbell, M. F.: Principles of Urology, Philadelphia, W. B. Saunders Co., 1957. 2. Colby, F. H.: Essential Urology, Baltimore, The Williams & Wilkins Co., 1953.

NITROFURANS—a unique class of antimicrobials—neither antibiotics nor sulfonamides

EATON LABORATORIES, NORWICH, NEW YORK

In spite of the enormous growth of the pharmaceutical industry and the tremendous investment that drug manufacturers put into research, the chances of their developing really new drugs that act along new principles . . . remain very small indeed. As a result only a very small fraction of the new preparations that are marketed each year represent such truly new drugs.

New England J. Med., Dec. 3, 1959, p. 1190.

Maltbie Laboratories is proud to announce such a truly new chemical entity: 1-maminophenyl-2-pyridone. Its name . . .

Dornwal[®]

for treatment of anxiety and tension
without causing drowsiness

therapeutically outstanding: effectively interrupts tension headache / relieves acute emotional upsets / does not produce depression or depersonalization / is well suited to ambulatory patients / is virtually devoid of hypnotic or sedative activity / patients remain alert without undue stimulation /

MALTBIE LABORATORIES DIVISION Wallace & Tiernan Incorporated Belleville 9, New Jersey

a tranquilizer with minimal side effects:

Look at the dramatically low incidence in an unselected group of 593 patients . . .

Symptoms	Patients	Symptoms	Patients
Drowsiness	9	Tinnitus	1
Sedation	2	Stimulation	3
Nausea	7	Insomnia	1
Pruritus	2	Dry mouth	8
Blurring vision	4	Exanthema	2
		Tremor	3

DROWSINESS WAS MINIMAL

(only 9 out of 593 patients: less than 2% . . . statistically not significant)

Prescribe Dornwal for your next patients who need a tranquilizer but cannot afford to be drowsy. Write for your trial supply.

Indications: anxiety and tension, various types of psychoneuroses, tension headache, menopausal syndrome, alcoholism, premenstrual tension, behavior problems in children.

Dosage: One or two 200 mg. tablets three times a day. Children, one or two 100 mg. tablets two times a day. Administration limited to three months duration.

Supply: 200 mg. yellow scored tablets, and 100 mg. pink tablets, each in bottles of 100 and 500.

No absolute contraindications to the use of Dornwal are known. There have been no reports or evidence of habituation, addiction or drug tolerance in animal or clinical studies. Dornwal has proved to be relatively free from untoward effects when administered at recommended dosage.

References: 1. Landis, C.; Whittier, J. R.; Dillon, D., and Link, R.: Clinical findings and psychophysiological tests of the effects of a new psychopharmacologic agent: Dornwal, Am. J. Psychiat. 116:747 (Feb.) 1960. 2. Litchfield, H. R.: Aminophenylpyridone, a new mood-stabilizing drug, Arch. Pediat., in press. 3. Cass, L. J.; Frederik, W. S., and Teodoro, J.: Evaluation of Calmative Agents: Revision of methods, Am. Pract. & Digest Treat., in press. 4. Nodine, J. H.; Bodl, T.; Levy, H. A.; Siegler, P. E., and Moyer, J. H.: The use of amphenidone as an ataractic agent in outpatients, American Federation for Clinical Research, New Orleans, Jan., 1960. 9. Cantelmo, A. L.: Clinical evaluation of aminophenylpyridone as a new drug for stabilizing emotional behavior, Current Therap. Res. 2:72 (Feb.) 1960.

Dornwal

Dornwal

POL-02

News

One approach to a resident matching program might be tried on a group-hospital basis, Dr. Darley says. Under such an arrangement the group of participating hospitals would agree to appoint only residency candidates who joined the plan, and candidates would agree to limit their acceptances to participating hospitals.

Billion-Dollar Business Bared by Quack Hunt

Possibly a billion dollars a year is spent on health care by people who slip through the fingers of the medical profession and deal instead with quacks. The Food and Drug Administration has now tracked down enough of the fakers to estimate their total take. "Literally thousands" have been found.

"Medical quackery is big business," warns George P. Lerrick, chief of the F.D.A. He figures that bogus cures and fake medical devices alone dupe the public out of \$250 million a year. One of them is a \$1 remedy for "muscle cramps"—simply a plastic bag into which the sufferer exhales, afterward inhaling his own exhalations five times. Another is a \$19.50 do-it-yourself electroshock treatment gadget. This is supposed to ease you in kidney trouble, goiter,

childbirth, and bone fractures.

But the really big money is raked in by "nutritional quackery." Lerrick estimates that health foods and nutritional supplements con the public out of more than \$500 million a year. Health-hungry people swallow spuels about "secret formulas" for seaweed supernourishment and "special" vitamins to remedy everything from cancer to sterility.

One company offers regular deliveries of its vitamin preparation at an annual rate that would assure legitimate medical care—\$193 per customer. And it has signed up more than 100,000 buyers, Lerrick says.

M.D.s May Need a More Liberal Credit Policy

Consumers are having less trouble borrowing money this year than in the recent past. As a result, doctors can expect to have more trouble collecting their bills. So the physician should "take a page from the merchant's book and remember that a liberal credit policy pays."

That's the advice of editors of the Orleans Parish Medical Society Bulletin of New Orleans. For the doctor, they see this discouraging credit picture:

"Until now, merchants competed mildly in extending credit to the consumer in order to sell more

Continued on page 48

**improved
peripheral
blood flow
now sustained
for 12 hours
with just one**

Priscoline® Lontab®



Improved circulation to the extremities can now be sustained all day or all night with just one Priscoline Lontab. Exclusive Lontab formulation offers rapid initial effect, steady, prolonged increase in blood flow to the extremities when circulation is impaired. Lontabs keep hands and feet warm without the chill periods of intermittent medication in patients with arteriosclerotic peripheral vascular disease, Raynaud's disease, thromboangiitis obliterans, postoperative and postpartum thrombophlebitis and similar conditions.

Complete information available on request.

Supplied: Priscoline Lontabs, 80 mg. (15 mg. outer shell, 65 mg. inner core).

Special outer shell actually contains initial dose of medication which is immediately released for rapid vasodilating effect.

Unique Lontab core designed to release medication gradually, sustaining vasodilating effect as long as 12 hours.

**C I B A
SUMMIT, N.J.**

PRISCOLINE® hydrochloride (tolazoline hydrochloride CIBA)
LONTABS® (long-acting tablets CIBA)

R/2622MK

in edema of pregnancy

"gratifying relief..."

in all patients

treated with



HYDRODIURIL®

HYDROCHLOROTHIAZIDE

increased potency—without corresponding increase in side effects

Ford, Ralph V.: Southern Med. Jl. 52: 40, (Jan.) 1959

"Hydrochlorothiazide was given to patients with edema (mild to moderate) of varied etiology..."

"There were... 5 women in the third trimester of pregnancy." In these patients the cumulative weight loss was 2 pounds after seven days of therapy and 4 pounds after twenty-one days. Gratifying relief of edema was observed in all patients.

DOSAGE: One or two 50 mg. tablets HYDRODIURIL once or twice a day, depending upon the condition and individual patient response.

SUPPLIED: 25 mg. and 50 mg. scored tablets HYDRODIURIL (Hydrochlorothiazide) in bottles of 100 and 1,000.

HYDRODIURIL is a trademark of Merck & Co., Inc..

Additional information on HYDRODIURIL is available to the physician on request. ©1960 Merck & Co., Inc.



MERCK SHARP & DOHME
Division of Merck & Co., Inc. Philadelphia 1, Pa.

News

goods . . . But now we see a competition, not for the consumer's dollar, but rather for the consumer's promise to pay the dollar later . . .

"Full-page ads urge the consumer to open a line of credit at the bank . . . Three national credit cards are pressed upon him . . . Department stores seem not to be interested in full payment on the tenth of the month, but encourage extended payments," the editors point out.

"The real interest rates paid for these credit privileges average about 16 per cent, which is that much of a reduction in purchasing power. But worse is the inevitable result that incomes will be far more heavily committed to 'convenient' budget payments . . . Where do you think the doctor, the involuntary credit grantor, will fit in this picture?"

Because he grants credit "on the basis of need rather than on the basis of financial statements," the doctor can expect to suffer credit losses of "at least 5 per cent and often 10 per cent, [or] more than thirty times the losses expected by the merchants and banks."

Even so, the doctor will be able to surmount such losses if he uses credit to build his own practice.

"It is obviously better to collect 90 per cent of a \$5,000 monthly practice than it is to collect 100 per cent of a \$2,500 practice," conclude the editors.

'Get the Hacks Out of Medical Society Offices'

"All medical organizations—county, state, and national—should give a lot more thought to the men they elect as their official spokesmen." That's the suggestion of one medical magazine's editors. In an editorial entitled "The Medical Politician," they explain:

"All too often the only qualification needed for a person to be elected is 'he's a willing worker and will take the time.' It doesn't seem to matter that the person may be totally incompetent, tactless, vulgar, commands poor or no respect, [or is] even a poor doctor—just as long as he has the time and wants the job."

The editors of California G.P. have heard other doctors justify their support of such incompetent officers with all sorts of excuses. For example: "There really isn't anyone else who is willing to run." "He has worked so hard for it, it's really a shame to hurt his feelings." "His wife would be awfully disappointed." "It's an honor due such a grand old man of medicine." And so on.

In the future, the editors hope



SPEED DURATION

IN ORAL CONTROL OF PAIN

ACTS FASTER—usually within 5-15 minutes. LASTS LONGER—usually 6 hours or more. MORE THOROUGH RELIEF—permits uninterrupted sleep through the night. RARELY CONSTIPATES—excellent for chronic or bedridden patients. AVERAGE ADULT DOSE: 1 tablet every 6 hours. May be habit-forming. Federal law permits oral prescription.

Each PERCODAN® Tablet contains 4.50 mg. dihydrohydroxycodeinone hydrochloride, 0.38 mg. dihydrohydroxycodeineone terephthalate, 0.38 mg. homatropine terephthalate, 224 mg. acetylsalicylic acid, 160 mg. phenacetin, and 32 mg. caffeine.

Also available—for greater flexibility in dosage—PERCODAN® DEMI: The PERCODAN formula with one-half the amount of salts of dihydrohydroxycodeinone and homatropine.

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Percodan® Tablets

Salts of Dihydrohydroxycodeinone and Homatropine, plus APC

FOR PAIN

*U.S. Pat. #2,628,185

PHOTO BY BEN KREMER, WORLD PICTURES

News

these excuses will give way to two kinds of action:

1. More qualified doctors "must be willing to take on these many times unrewarding jobs. [They don't] necessarily take a lot of time; they do take judgment and competence."
2. "Nominating committees and those doing the electing should delve deeply into a [candidate's] qualifications."

Considering how seldom these hopes are realized today, "it's amazing organized medicine has had as many fine leaders as it has," declare the editors. "There might have been a day when such offices were not important. Today that isn't true. Organized medicine plays a vital role in our medical economy and will largely shape the way we practice in the future."

Pediatricians Lead Migration To Suburban Practice

The physician, emulating millions of his patients, long ago joined the flight to suburbia. Since flocks of his migrating patients have been parents of young children, it's only natural that large numbers of pediatricians—more than some other specialists—have made the move. New light has now been shed on these medical migrants by a Den-

ver pediatrician, Dr. Seymour E. Wheelock.

When he counted Denver area pediatricians in 1939, they numbered just thirty. Two-thirds of them had offices in a few downtown blocks; the rest were no farther than four miles away.

Today a new count finds eighty pediatricians in and around Denver. Only four are left in the downtown offices. More than half have offices up to four miles away from downtown; another quarter have offices in the suburbs from four to ten miles away. And several others have hospital or public health jobs.

How are the doctors in each location faring? According to Dr. Wheelock:

¶ The doctors who've moved to the suburbs say they're doing very well. Most of them have gone into partnership. Many near-by parents have switched to them "to avoid the long trip across town with a sick child."

¶ The doctors who've stayed behind in the city are managing to hold on. "I'm just comfortably busy now instead of being too busy, as I was ten years ago," reports one downtowner. "But I sure wouldn't set up shop here now if I were just starting out."

¶ The doctors who've tried to keep a foot in both camps—by keeping two offices—are running

Continued on page 54

ENTER TYZINE

EXIT CONGESTION

Tyzine®

brand of tetrahydrozoline hydrochloride

NASAL SOLUTION / NASAL SPRAY (0.1%)

Dispels nasal congestion up to six hours or longer
Clinically successful in 95% of 2,576 published cases^{1-9*}
Virtually free of sting, burn, or rebound congestion

Note: As with certain other widely used nasal decongestants, overdosage may cause drowsiness or sleepiness in infants and young children. KEEP OUT OF HANDS OF CHILDREN OF ALL AGES. Use Pediatric Nasal Drops (0.05%) for children under six years.

1. Mengel, H. C. New York J. Med. 56:1279, 1956.
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9. Parish, F. A. M. Times 82:97, 1954. *These cases involved use of both 0.1% and 0.05% Tyzine in adults and children.

Professional information Available Upon Request

Pfizer Laboratories Division, Chas. Pfizer & Co., Inc. Brooklyn 6, N.Y. Science for the world's well-being™

The first full-range medication
for chronic gout and gouty arthritis
...new

Triurate*

provides comprehensive treatment by combining in one convenient dose:

FLEXIN® Zoxazolamine: the most potent uricosuric agent available¹⁻⁴

Colchicine: time-tested specific for gout—effective in preventing acute attacks^{1,5,6}

TYLENOL® Acetaminophen: effective, nonirritating analgesic⁷ which does not interfere with uricosuric action^{8,9}

the triple therapeutic action of TRIURATE provides all these clinical benefits:

- promotes maximum urinary urate excretion
- markedly reduces serum uric acid
- relieves chronic pain and discomfort
- lessens frequency and severity of acute attacks
- facilitates resorption of existing tophi...
- prevents formation of new deposits
- helps restore mobility
- maintains effectiveness with minimal side effects

*Trade-mark

Average Dose: One tablet three times a day after meals. Literature on method of administration and dosage is available upon request.

Supplied: TRIURATE is available as beige, 'scored' tablets, imprinted McNEIL, bottles of 50.

(1) Beland, E. W.: World-Wide Abstracts 3:11, 1960. (2) Kolodny, A. L.: J. Chro. Dis. 11:64, 1960. (3) Talbott, J. H.: Arth. & Rheumat. 2:182, 1959. (4) Burns, J. J.; Yu, T. F.; Berger, L., and Gutman, A. B.: Am. J. Med. 25:401, 1958. (5) Beckman, H.: Pharmacology in Clinical Practice, Philadelphia, Saunders, 1952, pp. 515-516. (6) Talbott, J. H.: J. Bone & Joint Surg. 40-A:994, 1958. (7) Batterman, R. C., and Grossman, A.: J.A.M.A. 159: 1619, 1955. (8) Connor, T. B.; Carry, T. M.; Davis, T., and Lovice, H.: J. Clin. Invest. 28:997, 1959. (9) Read, E. B.: Unpublished data.

U.S. Patent No. 2,880,985

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XUM



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News

into problems. Dr. Wheelock's own three-man partnership, for example, has a main office a mile and a half from the center of town and a second office eight miles away.

"The extra office hours we partners spend there puts us under terrific time pressure," he reports. "And when we're not there, a house call in that area can sometimes mean as much as a thirteen-mile drive.

"Besides, it took a lot of trouble to make a second file of patients' records. And it's expensive to pay a second office rental," adds Dr. Wheelock. The only reason he and his partners keep that office is that "it *has* kept our practice in that area from drifting."

Code Tells Doctors How to Walk, Talk, and Charge

Medical science may leap ahead all the time, but the art of medicine doesn't seem to change as fast. Some current ideas of what's proper even have roots in the ancient or medieval worlds, points out the Worcester (Mass.) Medical News. It cites these rules that guided doctors' conduct 600 years ago:

¶ "Dress soberly, like a clerk, not like a minstrel. Do not walk hastily, which betokens levity, or

too slowly, which is a sign of faint-heartedness."

¶ "When called to a patient, find out from his messenger as much about him as you can before you arrive. Then, if his pulse and urine tell you nothing, you can still surprise him with your knowledge of his condition."

¶ "When feeling the patient's pulse, allow for the fact that he may be disturbed by your arrival and by the thought of the fee you are going to charge him."

¶ "When asked how long recovery will take, specify double the expected period. A quicker recovery will redound to your credit."

¶ "Do not look lecherously on the patient's wife, daughters, or maid-servants, or kiss them, or fondle their breasts, or whisper to them in corners. Such conduct distracts the physician's mind from his work."

¶ "Avoid the company or friendship of laymen. They make a habit of mocking doctors, and, besides, it is not always easy to extract a fee from an intimate."

'Consultations' Via Radio Win Friends for M.D.s

Some medical communities have turned to local television show sponsorship as a means of improving their public relations. But at least one has found the older medium of radio better for gaining



To control
fear,
frequency,
and severity of anginal attacks

Equanitrate*

Meprobamate and Pentaerythritol Tetranitrate, Wyeth

EQUANITRATE helps control pain and accompanying anxiety in angina pectoris. It reduces the number and severity of attacks, increases exercise tolerance, and lessens nitroglycerin dependence.

A recent double-blind study† comparing meprobamate, a placebo, PETN, and EQUANITRATE states: "The best results . . . in both clinical and electrocardiographic response, were observed with a combination of meprobamate and pentaerythritol tetranitrate [EQUANITRATE]. . . ."

For further information on prescribing and administering EQUANITRATE see descriptive literature, available on request.

Wyeth Laboratories

Philadelphia 1, Pa.

†Russek, H.I.: Am. J. Cardiol. 3:547 (April) 1959.

Supplied: EQUANITRATE 10 (200 mg. meprobamate, 10 mg. pentaerythritol tetranitrate), white oval tablets, vials of 50. EQUANITRATE 20 (200 mg. meprobamate, 20 mg. pentaerythritol tetranitrate), yellow oval tablets, vials of 50.

*Trademark



A Century of
Service to
Medicine



*there's no juice
like citrus juice*

As a high-potency source of vitamin C, citrus juice—fresh, frozen, or canned—is unmatched for convenience and economy. The table below shows amounts[†] of other fruit juices required to supply the 100 mg.* of vitamin C in one glass (7-9 fl. oz.) of citrus juice.

citrus	1 glass
apple	50 glasses
grape	9 glasses
pineapple	3-4 glasses
prune	50 glasses



[†]Data calculated from: Watt, B. K. et al., U.S. Dept. Agric. Handbook No. 8, 1950; and Burger, M. et al. Agr. & Food Chem. 4:418, 1956.

*This is the peak of the Recommended Daily Allowances for adolescence or pregnancy; 150 mg. during lactation; 70-75 mg. for normal adults.

ORANGES
GRAPEFRUIT
TANGERINES

Florida citrus

FLORIDA CITRUS COMMISSION • Lakeland, Florida

friends. The key to the success of the Mahoning County (Ohio) Medical Society's half-hour weekly radio show is wide participation—both by the society's members and by the listeners themselves.

The show, called "Consultation," works like this:

A panel of three physicians gathers at a Youngstown radio station to answer medical questions called in by listeners. These questions are broadcast live, and the doctors' answers are off-the-cuff. Dr. Jack Schreiber is the panel's permanent "anchor man." As a family doctor, he discusses the questions and then refers them to the guest specialists.

These guests aren't always physicians. So listeners have been able to quiz a Blue Cross official on hospital costs, an insurance agent on health insurance, a local pharmacist on drug costs. Other guests on the schedule include a member of Alcoholics Anonymous, a local attorney, and a dentist.

What problems arise when the questions and answers are uncensored and unrehearsed? At first, Dr. Schreiber says, a few callers wanted panelists to diagnose their ailments over the air.

But for the most part, listeners want straight medical information—answers to questions that range from "What is a wart?" to "What is the cause and treatment of

News

Friedreich's ataxia?" Giving them the answers, Mahoning County's doctors have found, "can do wonders for the medical profession" in terms of goodwill.

G.P. Says Specialist Sees Patient Only Dimly

"There aren't many people who'd want the old family doctor now," said Dr. Robert V. Terrell in a newspaper interview. He had just been elected president of the Academy of Medicine in Richmond, Va.

The complexities of modern medicine, he explained, are such that "when you're sick, you don't want just any ordinary guy. You want the best."

Dr. Terrell is a full-time proctologist. Actually, he was commenting on the nostalgia that some people have for the days of the "old-time family doctor." But many who read the interview concluded he was contrasting today's specialist with today's G.P.—to the detriment of the latter. So Dr. J. Kirk Richardson defended his fellow G.P.s with this reply to the newspaper: "There is a greater need for the family doctor in these troubled times."

The proctologist "views the patient dimly, as in a rear-vision

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mirror," Dr. Richardson quipped. "I think his viewpoint is general among the younger specialists who have really never practiced medicine, just their specialty. This attitude is one reason for the lack of love today between the patient and doctor and why [patients] are continually changing physicians. They are looking for one who is not only interested in their ailment but also in them."

The G.P.'s final barb: "The specialist bears the same relation to medicine as the muffler man does to automotive engineering. He is only part of the system."

Medical Reporters Alerted To Four Untold Stories

Reporters for the lay press are often accused of garbling stories about "miracle cures" they don't really understand. But there's one "all too often overlooked" subject—medical economics—that can be understood by any lay reporter. By writing about it, he "can perform a major service for the public."

That's what a group of reporters-to-be were recently told by Robert D. Potter, who edits the journal of the New York County medical society. He urged journalism students at Michigan State

University to tell their future readers about "the new experiments in medical . . . economics that seek to bring better medical care to the patient at more reasonable cost."

For example, he named "a few dynamite stories" in medical economics that need "superior, objective, responsible" handling if the public is to get the straight facts. His nominations:

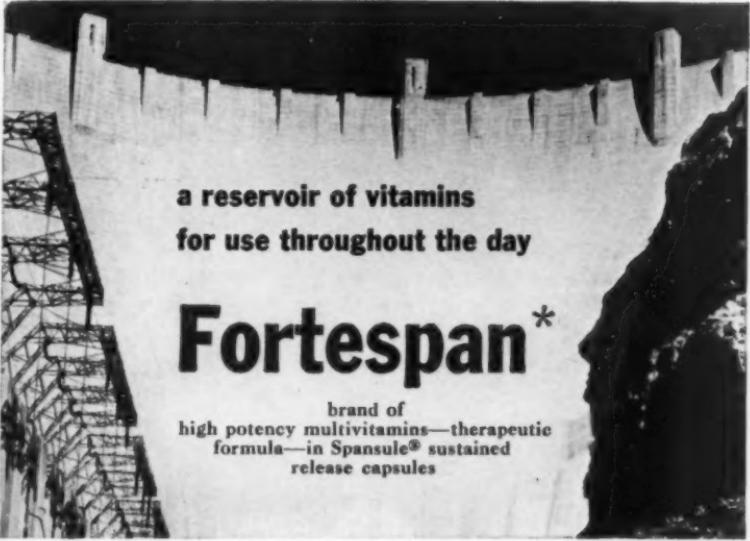
1. *Medical care for the elderly—the Forand bill.* Editor Potter suggested that future medical reporters explore such questions as this: If Government allocates a portion of Social Security payments to health care, what's to stop it from saying "that a certain portion has to go for food (and what kind) and housing (where and how much)?"

2. *Union-financed medical care plans.* "In smaller communities especially, these plans can disrupt the entire practice of medicine. The states of Kentucky and Colorado are prime battlegrounds in this area between doctors and the United Mine Workers."

3. *The hospital practice of medicine.* "How far can a hospital go in charging for and collecting fees for medical services rendered to patients in hospitals?"

4. *Medical publicity for fund raising.* "How far can . . . medical schools, hospitals, and the volun-

Continued on page 62



**a reservoir of vitamins
for use throughout the day**

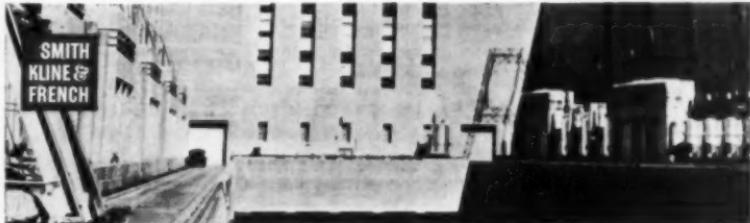
Fortespan*

brand of
high potency multivitamins—therapeutic
formula—in Spansule® sustained
release capsules

'Fortespan' acts as a reservoir of water-soluble vitamins, releasing them slowly for use by the body over a 10- to 12-hour period. 'Fortespan' is designed to provide more efficient vitamin utilization . . . with less waste. A high potency therapeutic multivitamin preparation, 'Fortespan' contains the fat-soluble vitamins (A and D) as well as the water-soluble vitamins (B Complex and C).

'Fortespan' is comparable in cost to conventional, widely prescribed therapeutic multivitamin preparations. Available in bottles of 30 and 100 capsules.

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highly effective

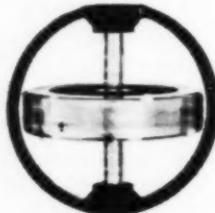
in respiratory allergies...

*unsurpassed for total
corticosteroid benefit*

Arist

Substantiated by published reports of leading clinicians

- effective control of inflammatory and allergic symptoms¹⁻⁸



- biochemical and psychic balance disturbance minimal^{1, 4, 5, 8-18}

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and
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LEDE

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well-tolerated control

ARISTOCORT

Triamcinolone LEDERLE

A Promise Fulfilled — All corticosteroids provide symptomatic control in rheumatoid arthritis, bronchial asthma and inflammatory dermatoses. They differ in the frequency and severity of side effects. Introduced in 1958, ARISTOCORT Triamcinolone bore the promise of high efficacy and relative safety.

Physicians today recognize that the promise has been fulfilled...as evidenced by the high rate of refilled ARISTOCORT prescriptions

Precautions: With ARISTOCORT all precautions traditional to corticosteroid therapy should be observed. Dosage should always be carefully adjusted to the smallest amount which will suppress symptoms.

Supplied:
1 mg. scored tablets (yellow)
2 mg. scored tablets (pink)
4 mg. scored tablets (white)
16 mg. scored tablets (white)

List of References 1-18 supplied on request.



LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N.Y.

News

tary health agencies go in publicity efforts to raise money? All too often [their] technique is to exploit not only the research efforts of physicians but to add personal publicity also."

Griping Is an Art, These Doctors Say

Doctors who continually find fault with the way their hospital is run now have a new set of rules to go by. The rules have been drawn up by the doctors who edit the Massachusetts Physician. Here's their guide to "gripemanship, the art of never really approving of anything."

Rule one: "The novice gripeman will usually do well to concentrate his efforts on the board of trustees. [If] the board is rather a quiet one, he will speak of [the members] as do-nothings who have no real interest in the hospital and its staff. Should the board be unusually energetic and active, it becomes proper to speak of the good old days when the trustees minded their own business and didn't interfere in the affairs of the staff . . ."

The editors expect that "as the faultfinder grows in experience, he will look for more challenging targets at which to aim." This should lead him to:

Rule two: Blame the nurses. "The nurse who takes pains to alert a physician to details of his patient's clinical course must be accused of trying to be a 'junior doctor.' If, on the other hand, a nurse fails to keep the physician fully informed, she is 'not doing her job.' "

Rule three: Blame the lab technicians. "If a patient with no evident blood loss is reported as showing a hemoglobin which varies by one-half a gram on successive days, it is good form to refer to this as a 'laboratory error.' It is particularly rewarding to make such a statement on grand rounds, with the pathologist present."

Rule four: Blame the dietary staff. "The diet for a pediatric patient is especially to be criticized as dull and unimaginative, even though the individual child is known to have limited his intake to peanut butter and jelly sandwiches for months before his hospitalization."

Rule five states that "only the most expert gripeman should turn his comments on his medical colleagues . . . Here the approach must be subtle and nicely balanced," warn the editors. Their suggestion for criticizing a medical staff president: If he "is gentle and unassertive, the idea should be suggested that he is afraid of the trustees or of the staff. If he is vigorous and zealous, the idea must be cir-

New freedom from embarrassment and distress of psoriasis!

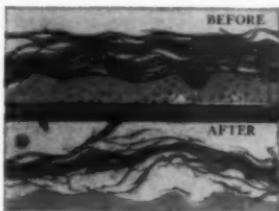
AlphosylTM LOTION

DISAGGREGATES PSORIATIC SCALE

In vitro studies show that the keratin-dispersing action of allantoin is exceptionally effective in disaggregating psoriatic scale.^{1,2} It apparently acts on an abnormal cement substance between cornified cells.^{2,3} Coal tar, too, helps break up the horny layer.² Together, these agents provide rapid clearing of psoriatic lesions as well as the underlying inflammation and erythema.

ALPHOSYL Lotion, used by many physicians both in routine practice and in carefully controlled studies, proved highly successful.^{2,4-7} The lotion permits complete avoidance of the potential hazards of certain other methods of treatment, such as superficial x-ray, heavy metals and corticosteroids.⁷

Advantages: • Treatment-fastness not observed • Cosmetic qualities permit free application to the scalp • Notably safe • May be freely used on tender areas



FORMULA: Allantoin 2% and special coal tar extract 5% in a greasleum, stainless, vanishing lotion base.

SUPPLIED: Bottles of 8 fl. oz.

APPLICATION: For maximum therapeutic results rub thoroughly into lesions 2 to 4 times daily. For maintenance apply once or twice a week.

REFERENCES: 1. Flesch, P.: Proceedings Scientific Session, Toilet Goods Assoc. June, 1958. 2. Samitz, M. H.: Ann. New York Acad. Sc. 73:1020, 1958. 3. Flesch, P., and Jackson Esoda, E. C.: Ann. New York Acad. Sc. 73:989, 1958. 4. Bleiberg, J., and Saltzman, J. A.: Clin. Med. 3:485, 1958. 5. Bleiberg, J.: Ann. New York Acad. Sc. 73:1028, 1958. 6. Clyman, S. G.: Ann. New York Acad. Sc. 73:1032, 1958. 7. Welsh, A. L., and Ede, M.: Ohio M. J.: to be published.



For psoriasis with
acute inflammation

Alphosyl-HCTM

Alphosyl with 0.2% hydrocortisone
Supplied in bottles of 4 fl. oz.



REED & CARNICK
Kenilworth, New Jersey

News

culated that he is the trustees' pet."

With these rules, a persevering gripeman can hardly go wrong. His only worry, declare the editors, is "a trap that has ensnared some of our most experienced gripemen:

"At all costs, beware of careless griping about the effectiveness of staff committees! If word of this reaches the president of the staff, the gripeman may find himself installed as chairman of the very committee with which he has found fault."

Union Snoopers Surprised At Medical Meeting

As the political furor over the Forand bill mounts, some friends and foes of the bill apparently are resorting to melodramatics to prove their points. Witness what happened at a recent clinical meeting of the Chicago Medical Society.

Fireworks reportedly started when two union photographers tried to take pictures of an anti-Forand bill exhibit for the A.F.L.-C.I.O. News. Here's how the union newspaper describes the "cloak-and-dagger antics" that ensued:

"The first photographer was interrupted by two men before he could take any pictures. The men demanded his personal and professional identification and the

identity of the customer who had engaged [him].

"Not satisfied with the cameraman's statement that he did not know the name of the client, the two men—one a burly six-footer—told him he was 'trespassing,' was 'not wanted,' and that if he was found near the display again 'drastic measures would be taken.' The men accompanied him down the elevator and out of the hotel."

The second photographer, the account continues, "hid a camera under his hat and managed to take one blurred picture . . . before an irate official told him that since he was 'not a doctor,' he couldn't take pictures."

What was the display the union wanted so much to photograph? The paper describes it as "a wide variety of slick brochures denouncing the Forand bill," and "an . . . actor rigged out as a circus barker . . . [who] lampooned the bill as 'payola for the Government.'" The barker showered fake gold coins on his audience to the accompaniment of this spiel:

"Uncle Sam is passing out money, all for free! Yes, sir, step right up for a Socialist handout! Big Brother wants to make all your decisions for you. Big Brother will look after you. Yes, sir, the Forand bill gives you freedom from want, freedom from fear, freedom from freedom!"

END

Preludin®

brand of phenmetrazine
hydrochloride

reduces the problems of reducing

In Simple Obesity

Preludin produces 2 to 5 times the weight loss achievable by dietary instruction alone.^{1,2}

In Pregnancy

Weight gain is kept within bounds, without danger to either mother or fetus.³

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Insulin requirements are not increased; they may even decrease as weight is lost.⁴

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References:

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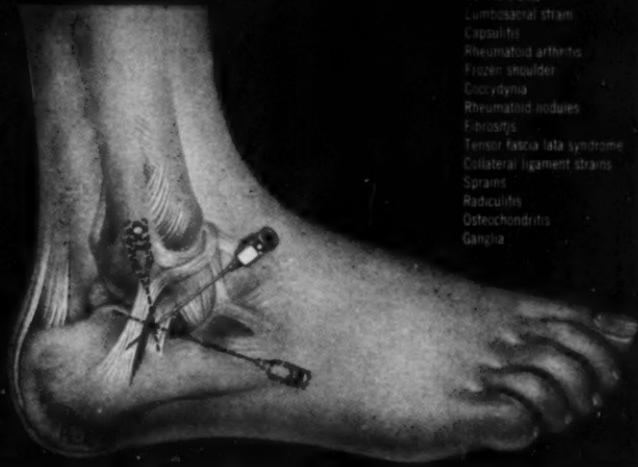
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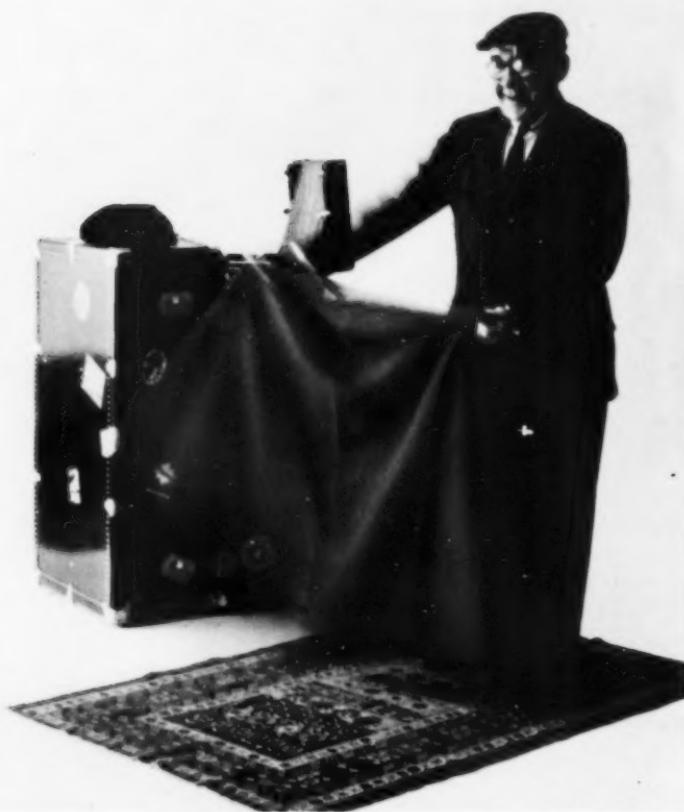


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Medical Economics

INDEPENDENT NATIONAL BUSINESS MAGAZINE FOR PHYSICIANS, MAY 9, 1960

How We Formed a Part-Time Partnership

Do you wish you could combine the satisfaction of solo practice with the less hectic pace of partnership? Consider the combination worked out by these two doctors

By Irving Stemerman, M.D.

Perhaps you'd like some relief from a doctor's eight-day week—but not at the price of giving up your independence. If so, take heart. A colleague and I have found a way. We've hit on a happy sort of arrangement that we call our "part-time partnership."

About four years ago, my pediatric practice began getting out

of hand. I welcomed my growing income. But I felt I couldn't go on coping with the never-ending, twenty-four-hour-a-day demands my practice made of me.

I enjoy working hard. But I also enjoy relaxing with my family. My wife and two daughters were seeing very little of me. I was constantly fatigued and irritable. At this pace, I knew that

THIS ARTICLE WON THE TOP 1960 MEDICAL ECONOMICS Award for its author, a pediatrician in Miami, Fla.

A PART-TIME PARTNERSHIP

my practice would eventually suffer.

In the same situation, some men might start looking for a partner. But I rejected the idea. First of all, I'm a lone wolf by temperament. Then, too, it seemed to me that a partnership would be wrong for these reasons:

¶ It would probably have meant a new office location, plus all the problems of merging two men's divergent routines.

¶ Although my solo practice

was terribly time-consuming, it still wasn't large enough to support two doctors.

¶ Even if a partnership practice became big enough to keep two of us busy, the doubled patient-load might well result in twice as many after-hours calls.

This outside-of-office-hours work was my big problem. I didn't want more free time in the office; I liked being constantly on the go there. What I needed was more free time *out of* the office. Which meant, I decided, that I

A BUSY SUNDAY at the office gives Dr. Irving Stemerman of Miami, Fla., a chance to spend the next Sunday with his family.



ought to find another pediatrician in the same boat. Why couldn't each of us keep his office practice intact while sharing the burden of evening and weekend calls?

I talked the possibility over with a colleague—a man of approximately my age and professional background. He said: "Let's see if we can't work something out." And we did.

Here's the plan we finally agreed on:

We would take alternate eve-

nings and Sunday afternoons off, on a regular but flexible schedule. Each evening the man going off duty would sign out to the other via the telephone answering service at about 7 o'clock. At 11, he'd receive from the answering service a list of all his calls that had been given to the alternate.

But he could count on hearing from his on-duty colleague directly—not through the answering service—about any unusual development. For example, sup-

HIS PART-TIME PARTNER is meanwhile spending a carefree afternoon with his daughter. He'll be on tap at the office the next week.



A PART-TIME PARTNERSHIP

pose the on-duty man hospitalized one of his colleague's patients. In such an event, he would telephone the other and give full details.

On Sundays, we would follow the same sign-out procedure, beginning at 1 P.M., following hospital rounds and early house calls.

You can see that our plan was simplicity itself. Two congenial doctors agreed to share the task of caring for patients in need of attention after the normal office day.

That was four years ago. Our

part-time partnership is still going strong.

But doesn't this much patient-sharing add up to a partnership in disguise? Not at all. Note these advantages that our system offers over a full partnership:

1. We retain economic freedom. We don't pool our income; we collect our own fees for any patients we treat.
2. There's no quibbling over office management, expenses, or hours.
3. We share no legal responsibility.
4. We each practice medicine



according to our individual lights. Neither needs to conform to the other's treatment methods.

How do parents react to our part-time pooling of their children's care? Better than we had dared to anticipate. At first there were protests from some people who were startled by the idea of not being able to reach their own physician at any hour. But most of those who grumbled have remained with us.

A few have gone elsewhere for medical care. But since some of these were the very people who habitually waited until after hours to place their calls, we've hardly regretted losing them.

Fringe Benefits

There have also been some unforeseen benefits from the arrangement. Now that we doctors keep more civilized hours, so do the parents of our patients! Many who used to wait until evening to call about an ailment now call during the day—to be certain they'll reach their own physician. And often a person who calls during the evening and learns that his own doctor is off duty

will cancel the call and wait until morning.

As a result, I can report a pleasant paradox. My practice has grown even larger since I entered a part-time partnership; yet I find that I get fewer night and Sunday calls when I'm on duty for both of us than I used to get for myself alone. What's more, most after-office-hours calls these days are truly necessary, not of the nuisance variety.

It's Not Rigid

Perhaps the best feature of our arrangement is its flexibility. Suppose we both want to be off duty at once—say, for example, to attend the same social or professional event. Then we simply pretend for the evening that our part-time partnership doesn't exist. Each man keeps in touch with his own practice through the answering service.

This flexibility also helps when one of us wants an entire week-end off. The other "partner" simply takes over. So that we won't both plan to be away the same week-end, we try to compare our

Continued on page 301

How 'Cheap' Health Insurance Can Rob You

From home offices in states with lax insurance laws, some companies are free to flood the nation with policies that are shockingly inadequate. Here's how they get away with it—and how you can do your bit to stop them

By William N. Jeffers

A few months ago, Urologist Sam G. Jameson of El Dorado, Ark., performed a transurethral resection of the prostate on one of his patients. Afterward, the patient assigned to the doctor the full benefit allowed for this procedure by his health-insurance policy, which covered him and his wife for a monthly premium of \$2.75. The insurance company then sent Dr. Jameson a check as payment in full. The amount: \$5.

Dr. Jameson sat right down and wrote a letter to the insur-

ance commissioner of Arkansas. "I would like to suggest," he wrote, "that this type of policy is certainly not in the best public interest . . . I seriously suggest that you consider rescinding approval of limited policies such as this."

In a way, the fact that such ludicrously inadequate "coverage" could be sold was none of Dr. Jameson's business—nor would it be yours. After all, the purchasers are adults. But in important other ways, it's very much your business. As an auth-

Job You and Your Patients

ority on health matters and a leading citizen in your community, you're rightly concerned with the cost and scope of health insurance.

In addition, there's the obvious matter of your fee. You may have a tough time collecting even a \$50 fee for a hysterectomy if a patient's policy allows only \$25. The patient may feel that the insurance company's fee schedule must be fair and that *you* are a fee gouger.

But beyond all that—well, Dr. Jameson puts it this way:

"The doctor-patient relationship extends not just to the patient's illness, but also to his payment for services rendered. I think it's part of my obligation to inform myself about health insurance. When it doesn't give a patient the help he's entitled to,

I feel I should give him general guidance on this subject."

Dr. Jameson also believes that, in cases like the above-mentioned \$5 prostatectomy, he should protest to his state's insurance commissioner. He does so as a matter of course—but with scant hope for resultant action. As a long-time member and current chairman of the Health Insurance Committee of the Arkansas State Medical Society, he has written many letters and had many meetings with state insurance authorities, in a constant effort to get the lax Arkansas laws tightened up.

So far, he and his committee have been pretty well stymied. Despite minor reforms, Arkansas remains a first-rate place in which to promote miserable health-insurance policies. As a



AN UNTIRING BATTLER against inadequate health insurance, Dr. Sam G. Jameson of Arkansas grimly looks over a policy that pays \$3 for major surgery. "If some states don't stop the sale of such insurance," he warns, "the Government may take over."

legal counsel to the Arkansas Department of Insurance has admitted, "The law is not very explicit in the regulation of health insurance."

You may well believe that the laws of *your* state amply protect you and your patients from worthless policies. If you do, you may be in for a jolt.

Take New York State. It has perhaps the strongest insurance laws and the largest and most vigilant insurance department in the nation. Like most states, it

has firm rules governing health-insurance ads. Yet, while cautioning its citizens to think twice before buying insurance from companies not licensed there, New York is legally powerless to prevent the sale of incredibly inadequate health-insurance policies from out-of-state companies. All other states are in the same boat.

One inadequate contract carries a clause stating that only half-payment will be made for conditions "not common to both

'CHEAP' HEALTH INSURANCE

sexes." Others present a short surgical schedule with the proviso (as in the policy held by Dr. Jameson's patient) that "for any cutting operation not otherwise specified in this operation schedule, a maximum of \$5 will be paid." In some, the maximum is \$3. In others, a proviso states that for procedures not specified "the fee will be fixed by the company." (In a recent North Carolina case, this led to the payment of \$17.50 for enucleation of an eyeball!)

Another policy sounds a lot better—if you read it very fast. It offers "the usual customary and regular charge" for "all drugs and laboratory examinations." But the reimbursement for any such "usual" charge "is not to exceed \$10."

Little Protection Here

Then, too, some contracts contain loaded exclusion clauses. These permit the company to escape certain responsibilities. For example, after the insured has been treated for a kidney infection, one company won't renew his policy unless he signs a rider

excluding the entire urinary tract from future benefits.

And, of course, a good deal of such coverage is renewable only "at the option of the company." Some is actually "cancelable by the company in accordance with standard provisions." This escape hatch may allow the company to cancel almost any time it pleases.

In well-regulated states, how does it happen that such policies are sold?

Mail-Order Policies

The answer is simple: They're sold through the mail by companies operating from states with feeble laws and supervision.

According to insurance men, among the worst offenders in this respect are Alabama, Arkansas, Illinois, Louisiana, Oklahoma, Tennessee, and—perhaps worst of all—Texas.

Says the insurance commissioner of a large Eastern state: "There's been more insurance trouble in Texas than in all the other states put together. They have let people go into the business there without sufficient

'CHEAP' HEALTH INSURANCE

capital or know-how. Texas insurance companies have had a terrible time trying to establish branch offices and get agents licensed in states that have decent insurance regulations."

But even the wildest companies can do a flourishing business in any state at all—through the mails. True, these outfits largely confine their operations to their own back yards, the South and Southwest, where they

prey mainly on the poor and illiterate. Yet no laws exist to keep them from reaching out into other areas. Says an official of the New York State Insurance Department:

"If an insurance company in another state does its business entirely through the mail, with no personal representative in our state, we are legally powerless to regulate or supervise it. Such concerns could walk off with the



"No, I'm not married. And I come up here once a month to make sure I never will be!"

people's money, and we couldn't do a thing about it."

The same situation holds true in every jurisdiction. The Federal Government can stop the mailing of clearly misleading insurance advertising, but such deception is usually difficult to prove in court. Besides, thousands of brochures may be distributed before the company is ordered to cease and desist.

Why Do They Sell?

Still, even in the worst-regulated states, the laws require that the provisions of any insurance coverage be spelled out in black and white in the contract. So why do people buy inferior policies?

Part of the answer, obviously, lies in the relatively low cost of most such policies. They're *false* bargains, but the price tag is seductive.

Their "cheapness" isn't the whole answer, though. Some of them are actually sold at rates comparable to those charged by reputable companies for good policies.

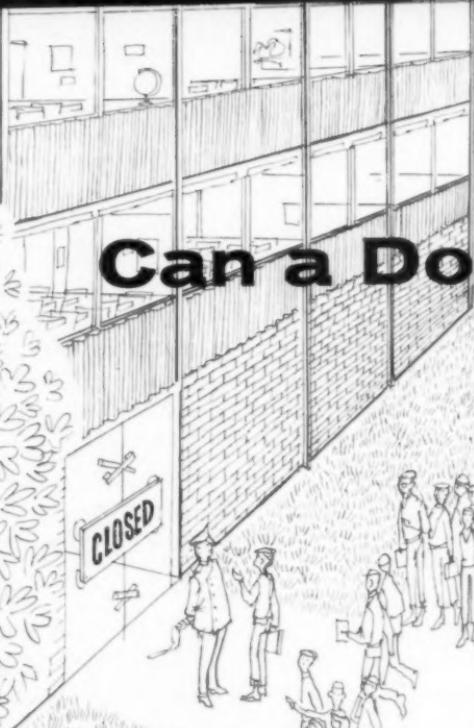
The main reason why poor coverage can be sold seems sim-

ply this: Even educated people almost never read the policies they buy; or else they seldom understand what they read. Remarks Paul A. Hammel of Nevada, president of the National Association of Insurance Commissioners: "I've been lecturing on insurance for many years before Rotary Clubs and other responsible groups. I often ask how many in the audience really understand their insurance policies. Nobody ever raises his hand."

The Dishonest Agent

Thus, health insurance is too often bought on the strength of agents' fast talk or of glowing advertisements. Says Arkansas Insurance Commissioner Harvey G. Combs: "My office handles five or six health-insurance complaints a day. And half the trouble is caused by dishonest agents. Not only do they misrepresent the policies; they sometimes actually commit fraud. People tell them the truth about their medical histories; but when the agent fills in the application for them,

Continued on page 302



Can a Doctor



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DOctors Afford to Be Controversial?

This physician played a leading role in a nonmedical battle that divided his community. Here—for anyone tempted to do likewise—he weighs the cost

By Paul Dawson, M.D.

"Stay clear of controversy . . . And don't mix in politics . . . A physician can't afford to take sides on public issues." This is the advice usually given to doctors by experienced colleagues, by public relations counselors, by well-wishers in general.

Yet the doctor is a free citizen who may hold strong opinions on many important subjects. Often he chafes at the traditional barrier that keeps him from fighting

for a nonmedical cause. An occasional man breaks through this barrier—prodded by conviction, indignation, or simply the love of a good scrap. Each who does so must ask himself, "How will this affect my practice?"

I believe I can give some answers to that question. They're drawn from my own experiences and from those of two doctors in a neighboring state. Each of us in our own way became pub-

THIS ARTICLE has won a 1960 MEDICAL ECONOMICS Award for its author, who practices in a large Southern city. Since the integration issue is far from settled in his community, and since his frank account of what has happened so far might strengthen the opposition to his activities, he writes here under a pen name.

CAN A DOCTOR AFFORD CONTROVERSY?

lately involved in one of the most controversial issues of our time: Southern school integration.

My community is one of many that recently had to face a clear-cut choice: Integrate the public schools or allow them to disintegrate. The degree of integration ordered by the Federal courts wasn't enormous—far from it. But ours was a key area in the segregationists' plan of resistance.

Accordingly, strong segregationist forces used highly emotional arguments to demand complete resistance to school integration.

Since their stand clashed head-on with the decision of the U.S. Supreme Court, something had to give. If the segregationists persisted, our public school system might be doomed. And I—a native Southerner and a moderate—felt strongly that I'd rather



"I'll tell you what's wrong with him! The lawn needs cutting, the garden needs weeding, the fence needs mending, the garage needs painting . . . that's what's wrong with him!"

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bow to the Supreme Court than see our schools closed.

Some of them did close, though. They closed for several months, because those who had the upper hand in our community refused at all costs to admit a handful of Negro students to white classrooms.

I couldn't stand by while our children's education was in jeopardy. I had to act, even though I suspected it would be more prudent for me to stick to medicine and let others fight the school battle. Actually, I soon realized, I was in a better position than many of those others to stand the economic strain of public controversy.

Who Is a Free Agent?

The merchant fears the reaction of his customers, the employe of his boss, the tycoon of his stockholders. Many lawyers are wary of taking sides; they need to keep friendly with the political "in" group. Architects and contractors want city contracts. Real-estate men face city zoning boards. School teachers have only one-year contracts. In

fact, almost everyone feels vulnerable if he takes a stand on a red-hot issue.

M.D.s Are Freer Than Most

The physician, I decided, is among the *least* vulnerable. If worst comes to worst in his community, he can generally use his talent and training to make a comfortable living elsewhere. Then, too, the doctor who gets into a public debate seldom runs the risk of hurting anyone but himself—at least, if he's a solo practitioner.

So with some qualms, but none the less sure I was doing the right thing, I joined forces with a group of like-minded neighbors—not the "leading citizens," but small businessmen, ministers, housewives, and professional people like myself. We formed an organization to preserve our city's public schools. I was elected one of the five officers.

From the start, we took what we thought was a moderate stand. We contended only that public schools must be maintained, re-

Continued on page 307

Best Performers Among t

*Are the funds doing the kind
Which ones are beating the market in general,
This objective analysis gives you a*

By Ralph J. Seymour

By the end of 1959, the American public had cast a \$16 billion vote of confidence in the mutual-fund industry. And, despite the early-1960 slump in market prices, investors are still putting millions more into the funds.

They seem made to order for the busy physician in particular. Instead of having to worry about building up his own portfolio, he puts his money in a common pool and knows that it's managed by professionals.

But is his faith in the funds—

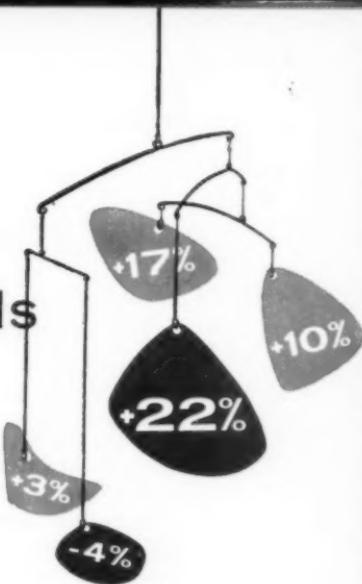
or in the special fund of his choice—really justified?

The recent past offers an excellent chance for finding out. It has been rough going for the average investor in common stocks. The year 1959 opened with a bang, right in the middle of one of the strongest bull markets in history. Soon, though, the boom ran out of steam. The market as a whole, as measured by Standard & Poor's 500-Stock Index, wound up with a respectable 8.8 per cent gain for the year. But while some issues doubled, oth-

THE AUTHOR is a Washington, D.C., economist and investment consultant.

g the Mutual Funds

*of job they're supposed to do?
which lagging behind?
helpful basis for comparison*



ers lost half or more of their value.

In the beginning of 1960, most of last year's gains were wiped away. Within the first forty-five days, Standard & Poor's index registered nearly an 8 per cent loss.

Meanwhile, how were the mutual funds faring? This magazine has analyzed forty-eight of the leading funds in the light of the following basic questions:

1. In general, how well did they fulfill their objectives within the viciously selective market of 1959?

2. How well did they cushion their investors against serious loss during the market drop of early 1960?

3. Which of the individual funds turned in the best performance in each of those periods? Which showed up worst?

4. How good a chance would the individual investor have had of beating the record of most funds?

Of course, there are many different types of fund, with different investment objectives. The performance of any one of them must be measured against what

BEST PERFORMERS AMONG MUTUAL FUNDS

How 20 Diversified Stock Funds Performed

*In 1959 and early 1960**

	Change in Value Per Share		
	12/31/58 to 12/31/59	12/31/59 to 2/15/60	1959 Dividend Income
Affiliated Fund	+ 9.5%	- 5.1%	2.9%
Broad Street Investing	+ 3.9	- 6.2	3.4
Bullock Fund	+ 4.1	- 6.4	2.8
Century Shares Trust	+ 3.2	- 6.2	1.8
De Vegh Mutual Fund	+10.2	- 9.5	1.3
Diversified Growth Stock Fund	+23.9	- 6.4	0.8
Dividend Shares	+ 3.3	- 6.9	0.3
Dreyfus Fund	+22.5	-10.2	2.0
Eaton & Howard Stock Fund	+ 7.3	- 6.7	2.2
Fidelity Fund	+ 7.6	-10.2	2.7
Fundamental Investors	+ 8.5	- 8.7	2.4
Group Capital Growth Fund	+ 0.2	- 9.1	2.7
Incorporated Investors	+10.2	-15.2	1.8
Institutional Growth Fund	+ 9.9	- 8.9	1.9
Keystone S-4	+27.1	- 8.1	1.2
Mass. Investors Growth Stock Fund	+13.9	- 6.6	1.5
Mass. Investors Trust	+ 6.0	- 8.4	2.9
National Growth Stock Series	+24.9	- 9.0	1.3
National Investors	+15.7	- 5.9	1.8
United Accumulative Fund	+11.8	- 6.4	2.9
<i>Average</i>	+11.2%	- 8.0%	2.0%
<i>Standard & Poor's 500-Stock Index</i>	+ 8.8%	- 7.9%	3.2%

*The calculation of per-share value assumes that capital-gain distributions are reinvested. The 1959 dividends from income are based on net asset value as of December 31, 1959.

it tries to do. The records of the five major types are summarized in the accompanying tables. But now let's go behind the raw statistics for each type and discuss what they reveal:

Diversified Stock Funds

This group includes some of the oldest and largest U.S. mutual funds. Though they may invest in bonds or hold some cash from time to time, substantially all their money is invested in a broad list of common stocks.

On the average, the diversified funds chalked up a creditable record last year. The twenty representative funds listed in the table scored an average gain in net asset value of more than 11 per cent. They also paid out income dividends averaging 2 per cent.

But those broad averages conceal some important cross-currents. Though these funds are alike in that they invest primarily in common stocks, there are big differences in their objectives. Some strive for relatively high income, some for capital gains, some for a balance between the

two. And investment objective apparently had a great deal to do with investment success during 1959.

The capital-gains-seeking funds fared the best of all, both when the market was going up and when it was going down. During 1959, they showed an average increase in value that was nearly double that of the market as a whole. For example, Massachusetts Investors Growth Stock rose 13.9 per cent; Diversified Growth Stock, 23.9 per cent; National Growth Stock, 24.9 per cent.

Equally striking was the way the growth funds hung on to most of their gains during the big market slide early in 1960. On the average, their net asset value dropped by about 8 per cent, leaving more than half their 1959 profits intact.

The funds that stress income didn't do nearly as well. As you might expect, they lagged in growth during 1959. For example, three prominent income-type funds—Massachusetts Investors Trust, Dividend Shares, and Broad Street Investing—

BEST PERFORMERS AMONG MUTUAL FUNDS

Showed gains in asset value of about 6, 3, and 4 per cent, respectively. That's significantly less than the 8.8 per cent increase of Standard & Poor's index.

What's more, they weren't able to hang on to their gains during the early part of 1960. All three of the income funds just mentioned lost more ground during the first forty-five days of

this year than they'd gained in 1959.

Naturally, the true test of a fund that emphasizes income is the dividends it pays. Even here the income funds didn't shine. They paid their shareholders between 1 and 3½ per cent, as against an average of 3.2 per cent for the stocks in the Standard & Poor index.

The stock funds that try to

How 6 Specialized Stock Funds Performed

*In 1959 and early 1960**

	Change in Value Per Share		
	12/31/58 to 12/31/59	12/31/59 to 2/15/60	1959 Dividend Income
Atomic Development Mutual Fund	+ 1.8%	- 4.3%	2.4%
Chemical Fund	+20.6	- 8.9	1.8
Energy Fund	+22.0	- 9.2	8.9
Group Food	- 2.4	-19.7	3.8
Group Tobacco	+ 6.5	- 5.7	4.5
United Science Fund	+22.4	- 9.5	1.4
<i>Average</i>	+11.8%	- 9.6%	3.8%
<i>Standard & Poor's 500-Stock Index</i>	+ 8.8%	- 7.9%	3.2%

*The calculation of per-share value assumes that capital-gain distributions are reinvested. The 1959 dividends from income are based on net asset value as of December 31, 1959.

steer a middle course—seeking both reasonable income and capital gains—landed midway between the others. In general, they lagged behind the market average by a percentage point or two during 1959; they lost all or

most of their gains in the opening weeks of 1960; and their dividends ranged between 2 and 3 per cent.

That's the broad picture of how the different classes of diversified stock fund have been

How 10 Balanced Funds Performed

*In 1959 and early 1960**

	Change in Value Per Share		
	12/31/58 to 12/31/59	12/31/59 to 2/15/60	1959 Dividend Income
American Business Shares	+4.2%	- 2.7%	3.8%
Boston Fund	+2.7	- 8.7	3.0
Commonwealth Investment	+3.3	- 4.3	3.0
Eaton & Howard Balanced Fund	+1.0	- 4.6	3.1
Investors Mutual	+3.7	- 4.7	3.3
Nation-Wide Securities	-0.2	- 2.2	3.6
The George Putnam Fund	+8.7	- 3.9	2.9
Stein Roe & Farnham Balanced Fund	+8.5	-10.4	2.3
Wellington Fund	+5.4	- 4.0	3.3
Whitehall Fund	+1.3	- 3.6	3.7
<i>Average</i>	+3.9%	- 4.9%	3.2%
<i>Standard & Poor's 500-Stock Index</i>	+8.8%	- 7.9%	3.2%

*The calculations of per-share value assumes that capital-gain distributions are reinvested. The 1959 dividends from income are based on net asset value as of December 31, 1959.

BEST PERFORMERS AMONG MUTUAL FUNDS

scoring. But note that there are a few striking deviations from the norm. For instance, Keystone S-4 appreciated 27.1 per cent in 1959—far more than the stock market as a whole. And it slipped back only 8.1 per cent (about the market average) during the January-February shakeout.

On the other hand, several funds showed 1959 increases in asset value of only about 3 per cent or even less—e.g., Century Shares Trust, Group Capital Growth Fund. And in early 1960, each of these lost far more ground than it had gained during the preceding twelve months. It's worth noting, though, that none of them took so bad a beating during this treacherous period as did many individual stocks.

Specialized Stock Funds

The funds in this group focus their investments in a single industry or in a complex of related industries. Inevitably, the fortunes of a given fund follow the fortunes of the industry in which it specializes. So the shares of these companies vary more wide-

ly than do those of the diversified types. Thus, they're also more speculative.

Many of the specialized funds did very well indeed in 1959—two to three times as well as the stock market as a whole. For instance, in a cross-section sampling of six of them, note that Chemical Fund shares rose about 21 per cent in net asset value (including capital gains). Energy Fund shares went up 22 per cent. Those of the United Science Fund gained something over 22 per cent.

What's more, the 1960 slump dissipated less than half the average gain chalked up by the above three funds. That's what you have a right to expect from dependable growth industries.

But, as I've said, everything depends on the fortunes of the industry that a specialized fund concentrates on. Those that put their money in lines that aren't in rapid-growth phases haven't done too well recently. Atomic Development Mutual Fund, for one, pretty much marked time in 1959 as far as share value was

Continued on page 314

How to Handle the 'Chiseler' In Your Practice

It's a rare doctor who hasn't at some time been asked to falsify facts and figures so a patient can collect bigger disability or health benefits. Here's how a cross-section of your colleagues react to and handle such situations

By Clifford F. Taylor



A San Francisco surgeon's patient asked him to bill Blue Shield for an abdomino-perineal resection instead of the cholecystectomy he was actually to perform. When the surgeon asked why, she pointed out with a knowing smile that Blue Shield would pay \$300 for the resection, only \$125 for the cholecystectomy.

The doctor thought it over for a moment. "Of course I can bill Blue Shield for a resection," he said with a smile of his own. "But you realize I'll have to do the operation I charge for."

The patient caught on. "She didn't mention it again," the surgeon recalls. "I did the cholecystectomy and charged only the proper fee."

That was how one physician handled an outright request for him to be a party to perjury and fraud. But it isn't always so simple for a doctor to handle the "chiseling" patient. Take the problem a urologist in a fair-sized Pennsylvania town had to face:

"A successful local contractor came to me over a year ago with

symptoms of unmistakable prostatism," he reports. "After treating him, I told him that it was no emergency, but that a prostatectomy was almost certainly indicated in the not too distant future. He asked a lot of questions about such an operation and the expenses involved. Then he left the office.

"Two months ago, he called and said he was ready for the operation. I had him admitted to the hospital and then operated. Later he brought me insurance forms to fill out. 'Actually, Doctor,' he said, 'I only started having real trouble with this prostate about a month before the operation. You don't have to put down anything about seeing me last spring.'

"I asked him how long he'd had the insurance policy. 'I guess I got it sometime after I saw you,' he said.

"Had he told the company when he applied that he expected to have an operation? 'Well, no,' he replied. 'You said I might have to have an operation in a couple of years, but they didn't ask about that.'

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DR. H. A. LINDHOLM of Armstrong, Iowa, would not testify in court that an auto accident had "caused" a duodenal ulcer of long standing. So his patient changed doctors.

"I pointed out that he had to sign the part of the insurance form that gave the company permission to review his medical records, and I explained that his original visit to me was on the record.

"With that, he exploded: 'Who in hell are you working for—me or the insurance company?'

"I left the questions blank. Naturally, the company then wrote me and asked about them. I sent back the true information. The company rejected the claim but refunded the patient's premium. My fee for the operation is still on the books. And now what should I do? Should I sue for my fee? Or should I charge

DR. W. E. ALLEN JR. of St. Louis was asked to change an X-ray date so his patient could collect for an old fracture. The doctor refused, lost both patient and fee.



HOW TO HANDLE THE 'CHISELER'

it off to experience and forgo the public relations damage that might result from suit?"

Thus can the chiseler pose a knotty problem in patient-relations. Observes a Newark, N.J., G.P.: "Otherwise lovely people, some of them good friends who wouldn't dream of cheating a newspaper coinbox of 5 cents, sometimes become cheats the minute they're covered by health insurance. It's a real problem for the doctor to remain on good terms with them and at the same time refuse to abet their 'innocent' attempts to cheat a hospital, insurance carrier, or the Government."

They Feel It's Justified

An internist in Philadelphia concurs: "Many patients can't see that chiseling an insurance company comes under any moral stigma. Their attitude seems to be, 'I've paid for this for years—now let *them* pay.'"

How widespread is this attitude? And how are the nation's doctors reacting to it?

To get some indication of the answers, MEDICAL ECONOMICS

recently asked 250 physicians across the country about their experiences with chiseling patients. In addition, the doctors were asked whether they felt it's the private practitioner's responsibility to crack down on such people.

A Common Attitude

Judging by their answers, the chiseling patient is no stranger to most doctors. Only twenty-two of the 250 physicians say they're never troubled by the breed. More than half the surveyed doctors run across such patients at least once a month. One-third encounter some form of attempted chiseling once a week or oftener.

In what general categories is cheating most prevalent? Attempted misuse of disability insurance coverage heads the list. Next comes abuse of hospitalization insurance, then of Workmen's Compensation, welfare programs, and major medical coverage, in that order.

A number of doctors also report that they've been asked to

Continued on page 324

They Don't Make Cars the Way They Used to

A doctor who bought his first horseless carriage in 1908 recalls the thrills of those early gas-driven days. Do you wish you'd been there to cheer him on?



By Harry A. Schatz, M.D.

Nowadays I drive a Dodge. It rides comfortably and never breaks down. It provides everything a car should—except excitement.

That's not the fault of the Dodge, of course. It's the fault of *all* modern cars. They're a drab necessity, where they used to be—take it from a man who owned one—a thrilling adventure.

Fifty-odd years ago, when I was a fledgling practitioner, an automobile was a new marvel. Nearly every established physician drove a horse and buggy in making his rounds. I naturally looked forward to the time when I could proudly do likewise. Yet, even more strongly, I yearned for an automobile.

I used to see one from time to time on the streets of Philadel-

THIS ARTICLE has won one of the 1960 MEDICAL ECONOMICS Awards for its author, an ENT man in Philadelphia.

THEY DON'T MAKE CARS THE WAY THEY DID



SPANKING-NEW MODEL S FORD is the best car yet, says Philadelphia's Dr. Harry A. Schatz (shown at the controls in spanking-new 1908 photo).

phia, where I lived. I was captivated not only by the looks of the rare "benzine buggy," but also by its smell. As a practical matter, though, a doctor could hardly afford to waste his money on such an impractical toy.

Then, early in 1907, a local physician's widow offered to sell me her husband's horse and buggy cheap. The offer precipitated a bold decision on my part. "Thank you," I said, "but I'm about to buy one of those automobile things!"

Having committed myself to the rash step, I couldn't conscientiously back down. So I began scanning newspaper ads and studying every small car I saw. Two models particularly attracted me: a Maxwell two-seater and a Ford Runabout. The Maxwell had two cylinders; the Ford, four. After due consideration, in August, 1908, I bought the new Model S Ford.

It looked and smelled magnificent. Most of it was bright scarlet; but there was a great deal of

dazzling brass exposed, including a bell-shaped horn, operated by a large rubber bulb, attached to the steering column. The wheels were equipped with 28" x 3" pneumatic tires. (No spare tire or extra wheel came with it.) The total cost was as spectacular as the product itself: \$788.

The salesman gave me one driving lesson, which chiefly taught me how to start the engine by cranking without fracturing my wrist; and home I drove. The very next day, I chugged along Chestnut Street in the center of town. I needed no driver's license, of course, and there were no red lights or stop signs. In such respects, the life of an automobilist was simple.

In others, though, it was exceedingly complicated. For one thing, I had to find a place to keep the car. A man I knew, a roofer by trade, owned a stable for his horse and wagon. I finally talked him into renting me some space there. So for about a year my car took its repose cheek by jowl with a mare. They apparently got on well together.

There was also the matter of

maintenance. There were no gas stations that I knew of, no commercial garages, no repair service other than that of the Ford agency itself. In a pinch, you were dependent on your own mechanical skill and the car's tool chest, whose contents included a jack, tire irons, and a grease gun.

It Took Know-How

With the latter, and with the oil can that rested in a bracket under the hood, I learned to replenish the numerous grease cups and oil cups the mechanism boasted. When poured into the proper opening at the front of the engine, the oil at first rested in the crankcase under the front cylinder. Then, when the motor was started, any excess oil would splash up past the piston head, fouling up the spark plug there, and the motor would falter. At regular intervals, I had to remove the spark plugs for cleaning.

Several days after I'd acquired my beauty, it gave me my first surprise: It stopped dead in the middle of the street. A bystand-

THEY DON'T MAKE CARS THE WAY THEY DID

er suggested that I might be out of gas. That seemed impossible, since gas had been put in the car before it was turned over to me. But a wooden ruler thrust into the tank, which was located under the seat cushion, proved the kibitzer right.

A Horse-Drawn Gas Station

Somehow, somewhere, I managed to find some of the rare fluid. Thereafter I ordered and received a five-gallon can of it every week; it was delivered to my home by a horse-drawn truck of the Union Petroleum Co. It was 8½ cents a gallon, tax-free.

When I'd driven the car a few weeks, I felt brave enough to invite a friend out for a spin. We'd sped a full mile into Fairmount Park when the machine suddenly coughed and stopped. I got down and cranked furiously. It refused to start again.

I had plenty of gas. What was wrong? My only recourse was to try to reach the Ford agency by telephone. This being Sunday, the chances seemed slim. But I was in luck: A man answered. It was the shop superintendent,

who'd dropped into his office for a box of cigars.

After questioning me, his diagnosis was that the six dry batteries, which furnished the electric spark to start the car by cranking and did other mysterious things, had probably run down. Soon he appeared in a large, red, six-cylinder Ford—a model not produced for public sale—and provided me with the needed dry cells. After that, I replaced the batteries regularly.

The Eternal Flame

The care and feeding of a 1908 Model S was no job for a sluggard. For instance, the beautiful brass carriage-lamps at the front and the smaller tail-lamp burned kerosene and needed frequent replenishing. Sooner or later, too, the wicks would begin to smoke, burn dimly, and deposit soot inside their glass windows. So trimming the wicks became another recurring chore. The best kind of tail-lamp was known as the Neverout; I often had trouble keeping it alight.

For protection against the elements, the car had an oilcloth

Why Clinical Judgment Often Dictates Altafur for Peroral, Systemic Therapy of Pyodermas

Gratifying Therapeutic Response

ALTAFUR was found "highly satisfactory in most of the primary and secondary bacterial dermatoses treated to date," including "pyodermas . . . caused by antibiotic resistant strains of staphylococci."¹ In a nationwide survey² there were 94% satisfactory results (cured or improved) among 159 patients treated with ALTAFUR for pyodermas.

Virtually Uniform *in vitro* Susceptibility of *Staphylococcus aureus*
99.5% of isolates (214 of 215) from patients with staphylococcal infections—including many antibiotic-resistant strains—proved sensitive *in vitro* to ALTAFUR in tests conducted across the nation.³ 99.7% of staphylococcal isolates (334 of 335) at a large general hospital—including many antibiotic-resistant strains—proved sensitive *in vitro* to ALTAFUR.⁴

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"Because of its relationship to previously developed nitrofurans, it is anticipated that [ALTAFUR] will retain

its original spectrum after longstanding clinical usage."⁵ Development of significant bacterial resistance to ALTAFUR has not been encountered to date.⁶

Minimal Side Effects

Side effects are easily avoided or minimized by these simple precautions: 1) alcohol should not be ingested in any form, medicinal or beverage, during ALTAFUR therapy and for one week thereafter 2) each dose should be taken with or just after meals, and with food or milk at bedtime (to reduce the likelihood of occasional nausea and emesis).

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1. Weiner, A. L.: Paper presented at the Conference on Recent Advances in the Treatment of Chronic Dermatoses, University of Cincinnati (Ohio), Nov. 5, 1959.
 2. Compiled by the Medical Department, Eaton Laboratories, from case histories received.
 3. Christenson, P. J., and Tracy, C. H.: Current Therapeutic Research 2:22, 1960.
 4. Glas, W. W., and Britt, E. M.: Proceedings of the Detroit Symposium on Antibacterial Therapy, Michigan and Wayne County Academics of General Practice, Detroit, Sept. 1, 1959, p. 14.
 5. Leming, B. H., Jr.: *Ibid.*, p. 22.
 6. Investigators' reports to the Medical Department, Eaton Laboratories.

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and 50 mg. (pediatric)

bottles of 20 and 100

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THEY DON'T MAKE CARS THE WAY THEY DID

top like that of any buggy, oil-cloth side curtains with celluloid panes, and a celluloid front curtain that could be rolled up and out of the way. In time the celluloid became opaque and cracks developed. For safe visibility, I had to ride with snow or rain pelting my face.

Still, I had no *real* trouble with the car for quite a long time. It was easily a few months before the truss rod went.

The truss rod was a long steel rod that extended under the rear axle from one brake drum to the

other. One day, it snapped off at one end and swung up and down, striking the axle housing and clanging horribly with each swing. To stop the din, I tied it down with wire till the agency was able to install a new one.

Another breakage occurred because the fenders weren't intimately attached to the body of the car. They were mainly supported by an iron bar, or fender iron. Every so often, a fender iron would snap loose, and the clatter would be terrific. But it

Continued on page 106



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	Each 0.6 cc. supplies the following Minimum Daily Requirements (MDR):
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(Synthetic)

Vitamin D 25 mcg... (1,000 U.S.P. units).....	2.5 MDR..... 2.5 MDR
Vitamin C 50 mg.	5.0 MDR..... 2.5 MDR

Supplied: 15 cc., 50 cc., both in amber bottles with separate, plastic calibrated dropper (0.3 and 0.6 cc.)

Each 0.6 cc. supplies
the following
Minimum Daily
Requirements (MDR):

	Infants Children
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Vitamin A 1.5 mg... (5,000 U.S.P. units).....	3.3 MDR..... 1.7 MDR
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(Synthetic)

Vitamin D 25 mcg... (1,000 U.S.P. units).....	2.5 MDR..... 2.5 MDR
Vitamin C 75 mg.	7 MDR..... 3.5 MDR

Supplied: 15 cc., 50 cc., both in amber bottles with separate, plastic calibrated dropper (0.3 and 0.6 cc.)

REDIPLPLE® POLYVITAMIN DROPS

Each 0.6 cc. contains:

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	Infants Children
Vitamin A 1.5 mg... (5,000 U.S.P. units).....	3.3 MDR..... 1.7 MDR

(Synthetic)

Vitamin D 25 mcg... (1,000 U.S.P. units).....	2.5 MDR..... 2.5 MDR
Vitamin C 75 mg.	7 MDR..... 3.5 MDR

Pyridoxine HCl (B₆)... 1 mg. (Minimum Daily Requirement not established)

Riboflavin (B₂)..... 1 mg. 2 MDR..... 2 MDR

Thiamine HCl (B₁)..... 1 mg. 4 MDR..... 1.5 MDR

Cyanocobalamin (B₁₂)... 3 mcg. (Minimum Daily Requirement not established)

Nicotinamide..... 10 mg. 2 MDR..... 1.3 MDR

Supplied: 15 cc., 50 cc., both in amber bottles with separate, plastic calibrated dropper (0.3 and 0.6 cc.)

REDIPLPLE® PEDIATRIC SYRUP

Each 5 cc. (1 teaspoonful)
contains:

	Each 5 cc. supplies the following Minimum Daily Requirements (MDR):
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(Synthetic)

Vitamin D 25 mcg... (1,000 U.S.P. units).....	2.5 MDR..... 2.5 MDR
Vitamin C 50 mg.	5 MDR..... 2.5 MDR

Pyridoxine HCl (B₆)... 1.0 mg. (Minimum Daily Requirement not established)

Riboflavin (B₂)..... 1.5 mg. 2.5 MDR..... 1.7 MDR

Thiamine HCl (B₁)... 1.5 mg. 6 MDR..... 2 to 3 MDR

Cyanocobalamin (B₁₂)... 5 mcg. (Minimum Daily Requirement not established)

Nicotinamide..... 10 mg. 2 MDR..... 1.3 MDR

Plus preservative and nitrogen propellant.

Supplied: 8-oz. delivery in 12-oz. aerosol

seamless can.

Each 5 cc. supplies
the following
Minimum Daily
Requirements (MDR):

	Infants Children
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Vitamin A 0.9 mg... (3,000 U.S.P. units).....	2 MDR..... 1 MDR
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(Synthetic)

Vitamin D 25 mcg... (1,000 U.S.P. units).....	2.5 MDR..... 2.5 MDR
Vitamin C 50 mg.	5 MDR..... 2.5 MDR

Pyridoxine HCl (B₆)... 1.0 mg. (Minimum Daily Requirement not established)

Riboflavin (B₂)..... 1.5 mg. 2.5 MDR..... 1.7 MDR

Thiamine HCl (B₁)... 1.5 mg. 6 MDR..... 2 to 3 MDR

Cyanocobalamin (B₁₂)... 5 mcg. (Minimum Daily Requirement not established)

Nicotinamide..... 10 mg. 2 MDR..... 1.3 MDR

Plus preservative and nitrogen propellant.

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THEY DON'T MAKE CARS THE WAY THEY DID

was easy to replace a fender iron; eventually, I always carried a spare in the tool chest.

Tires were a greater problem. Five months after I'd bought the car, I ran over a broken bottle and gashed a front tire irremediably. The replacement cost me \$22—which more than doubled the regular monthly expense of horseless-carriaging it.

The Ajax tires that came with the car had perfectly smooth treads. They'd cut easily. Then sand and dirt, entering the cut, would accumulate between the

rubber and the canvas casing. As a result, large strips of rubber would separate from the canvas, tear loose, and slap annoyingly with each turn of the wheel. I used to stop the noise—but greatly weaken the tire—by cutting the strip away.

As the car grew older, the springs started to go. Occasionally, one or more leaves would break at the center. Sometimes the entire spring would have to be replaced.

Finally, when it had reached the ripe age of 3½, my car died

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Thus, sudden endometrial change doesn't occur, withdrawal bleeding is rare. Artificial stimulation and "estrogen dependence" are avoided. Complicated dosage adjustment is unnecessary. Finally, there are no "peak-and-valley" estrogenic effects.

You can observe this unique effect in your patients. Simply prescribe two TACE 12 mg. capsules daily for 30 days. A severe case may require an additional 30-day course.

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THEY DON'T MAKE CARS THE WAY THEY DID

on the road. Though the motor was running smoothly, the car just wouldn't move. Investigation revealed that the cogs on the small gear at the rear end of the drive shaft had worn down to a smooth surface, and that for some time I'd been driving by friction alone.

That was the end of my wonderful Model S. I still mourn it. No car I've had since has given me such pure thrills as that primitive two-seater. It *wasn't* primitive in 1908, you see. It was modern science glitteringly em-

bodied. I feel sorry for a younger generation that has never known the incredible delight of cranking a carriage and making it go without a single horse to pull it.

But maybe my sorrow is misplaced. I have been reading lately about those wheelless autos that ride on air. Perhaps, fifty years from now, some other physician will nostalgically tell MEDICAL ECONOMICS readers about his experiences with one of the first wheelless autos. I'll enjoy reading that article if it happens to come my way. END

T *The unsophisticate*

When the time came to tell my 12-year-old son the facts of life, I began my previously prepared little talk with a true story. I told how a great athlete in a near-by large university had been given a chance at a college education because of his athletic prowess and then, two years before graduation, had tossed away his future by getting his girl pregnant.

My son's expression showed what an impact the story had had on him. But his comment wasn't quite what I expected. "Aw, Dad," he said, "why'd he do that when he could have played football? Didn't he know what to *do*?"

—M.D., ILLINOIS

For each previously unpublished anecdote accepted, MEDICAL ECONOMICS pays \$25 to \$40. Address: Anecdotes, Medical Economics, Inc., Oradell, N.J.

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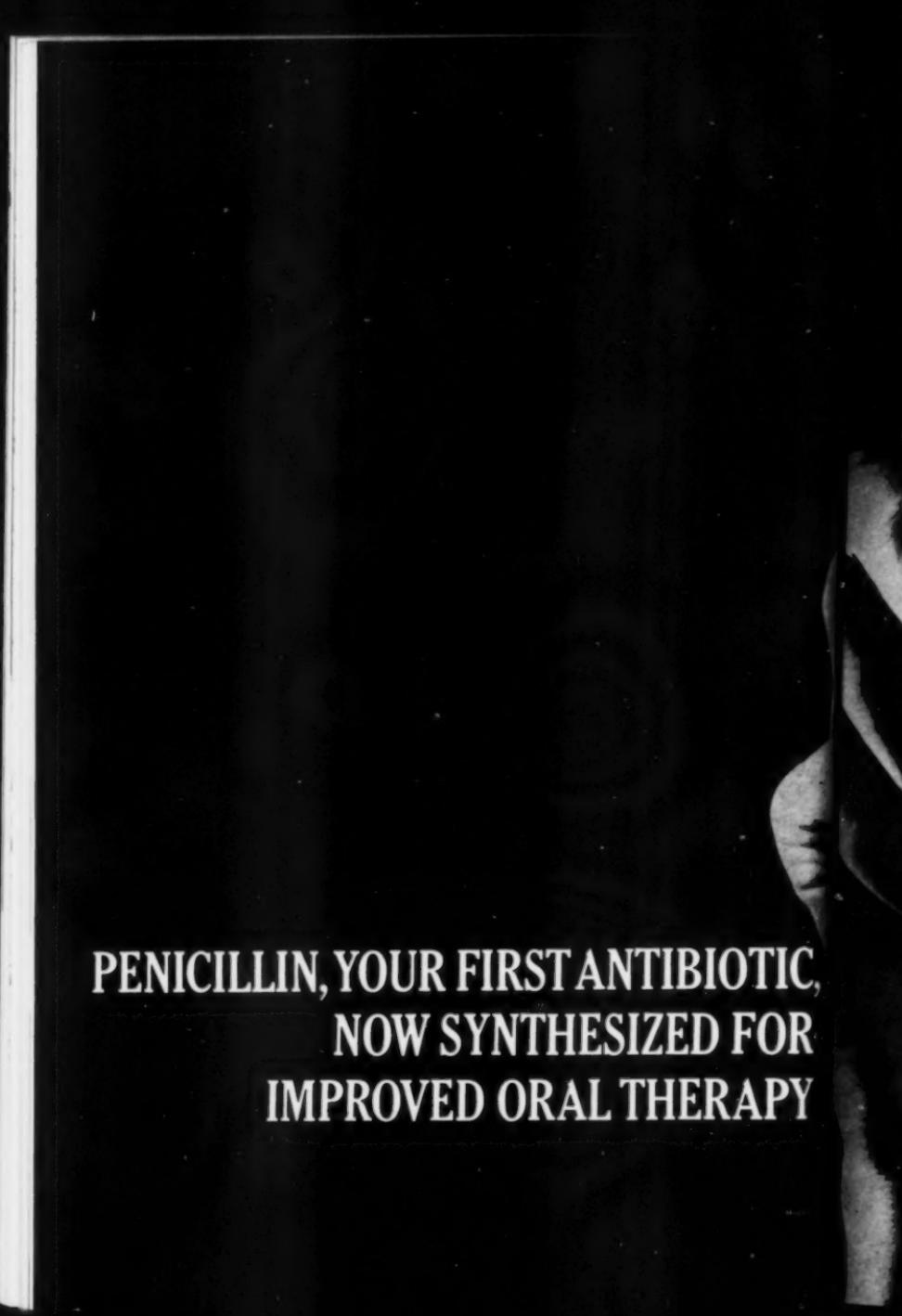
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1. Bennett, E. T. and McCann, E. C.: J. Maine M. A. 45:225. 2. Eichner, E., et al.: Am. J. Obst. & Gynec. 6:511. 3. Nulsen, R. O., et al.: Am. J. Obst. & Gynec. 65:1048.



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ALPEN has greater freedom from the G. I. sequelae (overgrowth of resistant flora) sometimes observed with broad spectrum-mycins.

ALPEN gives much higher antibiotic levels within the first hour of ingestion by the well-tolerated oral route.

WHEN TO USE ALPEN Recommended in the treatment of infections caused by pneumococci, streptococci, gonococci, corynebacteria, and penicillin-sensitive staphylococci.

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Tablets : 125 mg. and 250 mg., bottles of 25 and 100.
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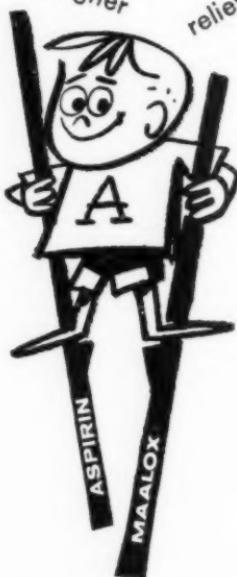
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What You Need to Know About Abandonment

This close-up look at some fine points of the laws dealing with a doctor's desertion of his patient may suggest extra precautions you can take to avoid suit

By George Willard

After a long and busy day, Dr. Blackman is at home, dozing in his favorite chair. Suddenly the phone rings. "Dr. Blackman? Oh, thank heavens!" a voice says. "This is Mrs. Joe Jones. All of a sudden, my husband seems terribly sick. Can you come right over?"

"Joe Jones?" says Dr. Blackman. "Sorry. He's not one of my patients—I've never heard of him. Afraid you'd better find another doctor." And Dr. Black-

man drops the phone back into its cradle.

Next, Mrs. Jones calls Dr. Manton. Like Dr. Blackman, he is enjoying a quiet evening at home. But he willingly rushes to the patient's side and renders what assistance he can.

A month later, Mrs. Jones again calls Dr. Manton. This time, he's out on a house call. When his aide reaches him, he tells her to give Mrs. Jones the name of another physician. Aft-

WHAT YOU NEED TO KNOW ABOUT ABANDONMENT

er all, Dr. Manton reasons, Jones was merely an emergency case he happened to handle, not one of his regular patients.

But while Mrs. Jones is trying to find a doctor, her husband suddenly dies. And his heirs lose little time in bringing a suit charging abandonment.

Which Man Do They Sue

They don't bring it against Dr. Blackman. Dr. Blackman's moral position may be a bit shaky. But his legal position is unassailable. In refusing to treat Joe Jones, he merely took advantage of an accepted medico-legal principle: that no doctor need take on a patient he doesn't want.

Dr. Manton is not so fortunate. By responding to Mrs. Jones' first plea for help, he legally made her husband his patient. And by failing to visit Joe Jones again when he was needed, Dr. Manton left himself wide open to an abandonment charge.

This story illustrates why you need to know the fine points of

the law on abandonment. So let's take a close look at the subject. Studying its various aspects now may help you avoid suit later on.

First of all, just what is abandonment? It's simply the culpable termination of a physician-patient relationship by the physician. True, no neatly codified body of law defines precisely the circumstances under which a physician is guilty of it. But court rulings over a number of years have created precedents. And there has been such wide agreement on so many similar cases of abandonment that it's possible to make some important—if generalized—observations on the subject.

Here they are, in question and answer form. Bear in mind that state laws vary, so that what's true of the U.S. in general may not always be true in your locale.

If a physician does accept a patient, may he limit his services in any particular way without opening himself to a charge of abandonment?

Yes, if he makes it clear to the

THIS ARTICLE is based on an analysis of recent court decisions in abandonment litigation. The conclusions have been checked by leading legal authorities in this field.

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WHAT YOU NEED TO KNOW ABOUT ABANDONMENT

patient beforehand that he's doing so. Even if he's a G.P., he can agree to treat only a certain ailment or a certain injury—and to do so only at a certain time and place (e.g., no house calls). The important proviso: that he make these arrangements in advance.

If the doctor doesn't impose any such special terms, may a patient demand treatment at a special time or place?

He may demand special treatment, but he's not legally entitled to it. In one case, a patient without an appointment charged his

doctor with abandonment simply because the physician refused to treat him ahead of other patients who were lined up in the waiting room. The court ruled: "The doctor was not shown to have been guilty . . . in not abandoning his other duties and making the plaintiff a preferred patient."

When the doctor feels that his personal attention is no longer a matter of medical necessity, is he open to abandonment charges if he refuses to see a patient who still complains about his original ailment or injury?

Continued on page 122

HOW TO AVOID AN ABANDONMENT SUIT

Under normal circumstances, no plaintiff's lawyer is likely to advise his client to sue for abandonment if the physician in question has abided by the following simple rules:

1. Always state explicitly and ahead of time any restrictions you plan to place on your services to a patient.
2. When you end your relationship with a patient, send him a formal statement of that fact. And offer to help him find another physician.
3. If a patient appears to have abandoned you, get in touch with him one way or another to make sure. And keep a record of your findings.
4. When you render emergency care, keep as detailed records as you would when treating your regular patients.

the
margin
of
difference
in
respiratory
tract
infections

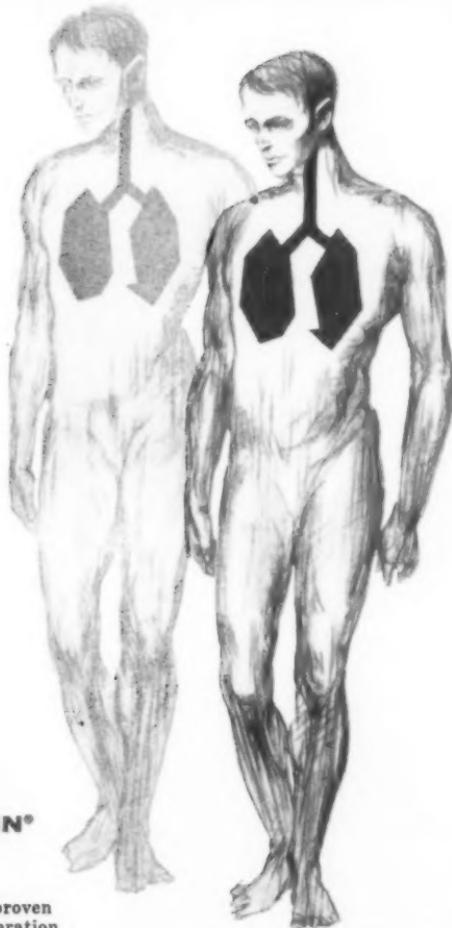
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WHAT YOU NEED TO KNOW ABOUT ABANDONMENT

No. But he'd better be sure he has given the patient specific instructions on any further care of the condition that seems called for.

Failure to take this precaution cost one Southern orthopedist \$25,000. Commented the court: "Where personal attention is no longer necessary in the treatment of an injury, the physician must,

if the case calls for it, furnish the patient with instructions as to its care."

Suppose a physician just wants to get rid of a patient, for one reason or another. Is he within his legal rights in dismissing any patient at all?

Yes. But first he should make sure he has given the patient ev-

Continued on page 126



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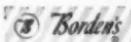
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Since food allergy creates clinical problems requiring individualized management, the disadvantages of a "fixed" formula are apparent.

MULL-SOY, however, provides all the management flexibility of evaporated milk, and may be used in the same way.

Type and quantity of carbohydrate—and degree of dilution—can

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WHAT YOU NEED TO KNOW ABOUT ABANDONMENT

ery opportunity to obtain the services of another competent physician. And he should send a letter to the patient making his act official. (Form letters will stand up in court if they're properly dated, addressed, and signed.)

But what if it's a family matter? Suppose a pediatrician treating the oldest two children in a family feels he can't handle a third. Can he be charged with abandonment if he refuses to treat the latest-born?

Not unless he has agreed with the mother to take care of all her children.

Emergency Cases

What about an OB man who makes an emergency delivery? If he refuses to continue treating the baby, can he be charged with abandonment?

Yes. Whatever the circumstances, the baby he delivers is the doctor's patient legally until another physician actually takes over the case.

If a physician turns over his emergency case—whether a newborn child or a hit-and-run vic-

tim—to another doctor, is he in the clear?

Correct. The first doctor has done his duty when he arranges for further care in a hospital or makes reasonably sure that another equally competent practitioner will carry on where he has left off.

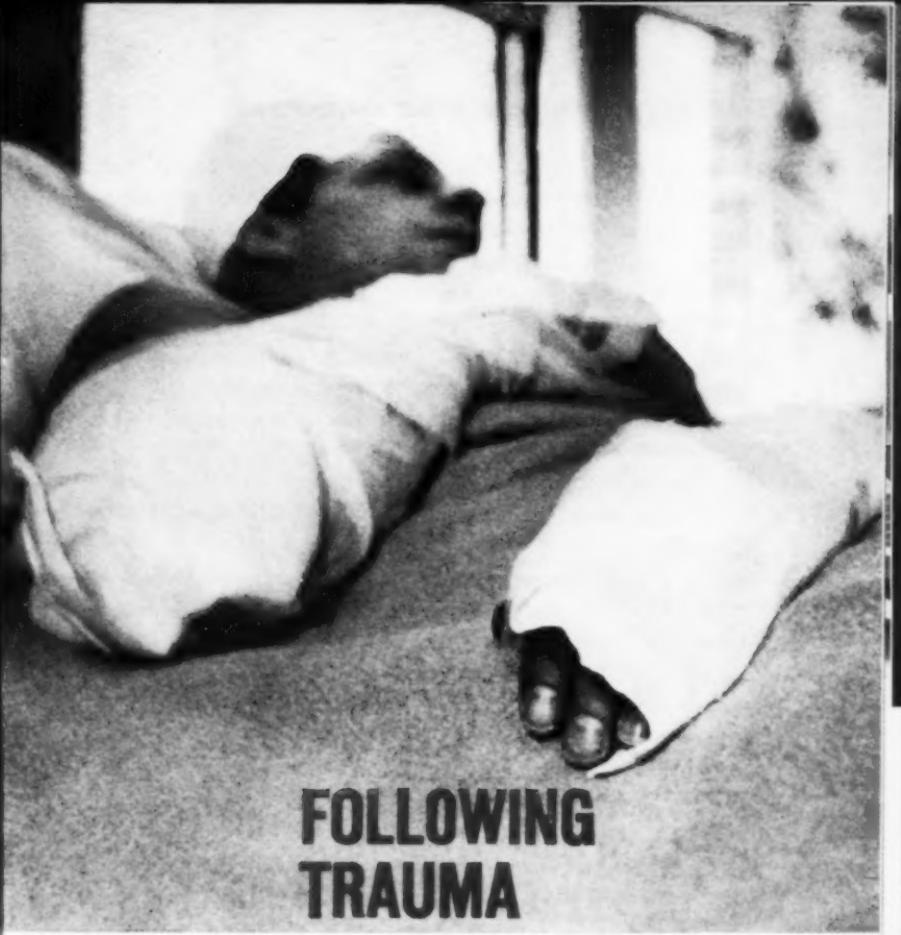
It's Best to Have Proof

When a physician has told an emergency patient to see another doctor, how can he prove it in court?

By producing notes made immediately after the incident, with the names of any witnesses, or—even better—the carbon copy and receipt of a registered letter in which he restated his instructions.

Let's consider the case of a Western physician who failed to take any of these precautions after applying a temporary splint to the broken arm of an auto-accident victim:

The injured man charged that the doctor had told him only that the dressing shouldn't be disturbed for several days. The arm had never been properly set—be-



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Each capsule contains: Thiamine Mononitrate (B₁) 10 mg., Riboflavin (B₂) 10 mg., Niacinamide 100 mg., Ascorbic Acid (C) 300 mg., Pyridoxine HCl (B₆) 2 mg., Vitamin B₁₂ 4 mcgm., Folic Acid 1.5 mg., Calcium Pantothenate 20 mg., Vitamin K (Menadione) 2 mg. Average dose: 1-2 capsules daily.

1. Richardson, M. E.: *J. Am. Osteop. A.* 57:562 (May) 1958. 2. Mason, M. L.: *Northwest Med.* 57:1439 (Nov.) 1959. 3. Coleman, S. S.: *Am. J. Surg.* 97:43 (Jan.) 1959.

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STRESSCAPS®

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WHAT YOU NEED TO KNOW ABOUT ABANDONMENT

cause, the doctor alleged, the patient hadn't taken his advice to see another doctor immediately. But the medical man had no proof of his allegation. A sympathetic jury found for the layman.

Does the gravity of a patient's condition influence the outcome of an abandonment case?

It may not affect the verdict. But it can affect the amount of damages awarded. In ruling against a surgical partnership charged with abandonment, one Midwestern court has put the case this way: "A physician who leaves a patient in a critical stage of disease without reason or suf-

ficient notice to enable him to procure another physician is guilty of culpable dereliction of duty, for which he is liable."

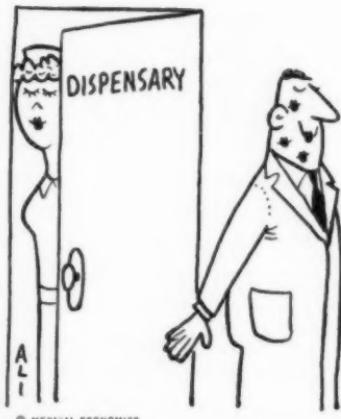
That doesn't imply that you're free to leave your noncritical patients, of course. It merely points up your greater culpability if you abandon those who are seriously ill.

What of Emotional Damage?

Must injury or illness be of a purely physical nature for an abandonment charge to stand up in court?

No. The law protects the patient's personality as well as his physical integrity. Thus, emotional damage may be just as compensable as physical damage.

In a widely publicized abandonment case, a young woman charged her doctor with failing to live up to his prior agreement to deliver her baby by Caesarean section. The doctor had flatly refused to perform the operation on schedule and in effect had told the patient: "Don't call me. I'll call you when it's time." The child was delivered dead. *More*►



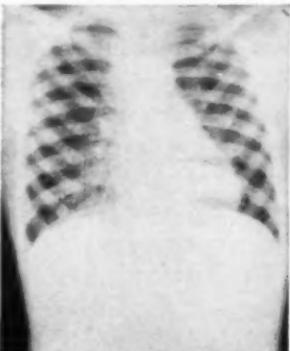
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Supplied: As 4 mg. tablets in bottles of 30, 100 and 500; as 2 mg. tablets in bottles of 30 and 100; and as 16 mg. tablets in bottles of 50.

1. Massell, B. F.: Paper presented at
A Symposium on Steroid Therapy,
Chicago, Ill., May 15-16, 1959.

*TRADEMARK, REG. U. S. PAT. OFF.—
METHYLPREDNISOLONE, UPJOHN

WHAT YOU NEED TO KNOW ABOUT ABANDONMENT

Finding for the plaintiff, the court observed: "In contracts involving rights cherished, dignities respected, and emotions recognized by all as both sacred and personal, the award of damages for mental distress and suffering is commonplace."

In asking damages for injury suffered in an abandonment case, must the plaintiff prove beyond doubt that the physician's absence caused the injury?

No. Probability suffices. Here's what the court ruled in the case just cited: It was not required that [the] jury find with absolute certainty that the baby would have lived if the operation had been performed . . . Probabilities are sufficient . . ."

What about a surgeon's liability for after-care?

After an operation, a surgeon is legally required to continue attending a patient only to an extent previously agreed upon.

This point was made clear a few years ago when a patient charged a Western surgeon with abandonment. The surgeon had refused to travel from his office to the patient's home in another

city to render after-care. But the court held the plaintiff had no case. The ruling, in effect, went like this:

"If a surgeon does not undertake to treat a patient until cured—and contracts to give service only at his office—he cannot be found guilty of abandonment because of his refusal to go to a patient's residence."

Substitute M.D.s

Is an absent doctor responsible for a covering man's derelictions?

He may be, if the patient can prove the physician has failed to exercise "due care" in selecting the man who covers for him. Here's a case in point:

A Northwestern woman, painfully injured in a household accident, was rushed to her doctor's office for emergency treatment. But when she got there she discovered that her doctor was out of the city—and that his office was being covered by a substitute physician.

Weeks later, when she brought charges of abandonment against her doctor, she argued, in effect,



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From a report to the Council on Foods and Nutrition of the A.M.A.:

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—Moore, C.V., et al.: J.A.M.A. 162:198.

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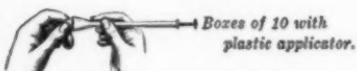


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*Shanphy, J.F.: *New York Jour. Med.*,
55:1335, May 1, 1955.

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Sanitary • Assures correct placement.

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Milibis (brand of glychitosal), trademark reg. U.S. Pat. Off.

ABANDONMENT

that the substitute wasn't as competent as her own man. The substitute, she said, had "wholly failed to take X-rays or perform the most simple tests" in his treatment of her injuries. And the court agreed. The woman's physician—and not the substitute—was forced to pay \$2,000. Here's the opinion in the case:

"A physician, hired by another physician to do his work for him in his absence, is a 'general agent' and not an 'independent contractor,' rendering the employing physician liable . . ."

. What about the substitute himself? Can he be sued for abandonment?

Yes. In one case some years ago, a doctor was called away from one of his own patients to do an emergency delivery. He then returned at once to his patient's side. When the baby he'd delivered lost its eyesight, he was charged with abandonment on the ground that he'd failed to place silver nitrate in the infant's eyes—that, in effect, he'd abandoned the patient at a crucial moment.

In his defense, the physician
Continued on page 136

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S



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method to
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The Fertility Testor, recently developed as the result of 18 years of research by Dr. Joseph B. Doyle of St. Elizabeth Hospital, Boston, Massachusetts, operates on the principle that a woman secretes glucose in the cervical mucous cascade approximately 3 days prior to ovulation.

It is for determining the presence of this glucose that the Fertility Testor has been developed.



The Fertility Tape used in this test has been proven completely safe for use in internal testing.

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OTTAWA, ILLINOIS



ABANDONMENT

argued that he'd been called in as an emergency substitute and that he shouldn't have been expected to show the same diligence as the regular attending physician. But the court ruled otherwise, awarding \$5,000 damages: "The substitute doctor had accepted responsibility . . . It was his duty to properly care for the child. But he neglected his duty."

Is a specialist guilty of abandonment if he refuses to treat an ailment that's out of his field?

No. If the limits of his specialty have been clearly spelled out in advance, the specialist is under no obligation to go beyond those limits. Thus, for example, an ophthalmologist may legally refuse to care for any of his patient's physical ills not directly connected with his eyes.

What about the physician whose patient abandons him? Is he responsible for a man he has not seen in years?

Probably not. But it's none the less wise to send the usual letter confirming the termination of the relationship. After all, a patient may decide to charge

Continued on page 141



*for
the
tense
and
nervous
patient*

relief comes fast and comfortably

- does not produce autonomic side reactions
- does not impair mental efficiency, motor control, or normal behavior.

Usual Dosage: One or two 400 mg. tablets t.i.d.

Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets or as MEPROTABS®—400 mg unmarked, coated tablets.

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- no irritating steroid particles, no sting, stain, smell, stickiness

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active ingredients

Product	Steroid Concentration	Dexamethasone 21-Phosphate (as the disodium salt)	Neomycin Sulfate	Supplied
NeoDECADRON Topical Cream	0.1%	1 mg./Gm.	5 mg./Gm. (equivalent to 3.5 mg. neomycin base)	5 Gm. (1/2 oz.) tube 15 Gm. (1/2 oz.) tube
DECADRON® Phosphate	0.1%	1 mg./Gm.	—	5 Gm. (1/2 oz.) tube 15 Gm. (1/2 oz.) tube



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all insomnia
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0.25 Gm., 0.125 Gm. SUMMIT, NEW JERSEY
DORIDEN® (glutethimide CIBA) 2/2761MB

ABANDONMENT

abandonment whether or not his grounds are solid.

Is abandonment a common charge?

Not right now. But it might well become so if the shortage of doctors is aggravated. In such an event, the physician who takes on too many patients would be particularly vulnerable. The justices of one court recently made this statement about two doctors facing abandonment charges: "We think it is not the law that doctors can take on so many patients that they will be excused if they neglect some of them and harm results from that neglect."

* * *

All the above points are based on actual court rulings. They make it clear that, more than any other factor, it's the physician's failure to take certain simple precautions that leads to an abandonment suit. If you follow the four guides set forth in the accompanying box, you're likely to avoid trouble.

As the tale of Dr. Manton shows, the best-intentioned physician may be the easiest target for an abandonment charge unless he's careful. END

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SMOOTH-MUSCLE SPASM...

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Profound
Protection...at both ends of the vagus

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Combined as Pro-Banthine with Dartal these two reliable agents consistently control both disturbed mood and disordered motility when emotional disturbances project themselves through the vagus to provoke such gastrointestinal dysfunctions as gastritis, pylorospasm, peptic ulcer, spastic colon or biliary dyskinesia.

Usual Adult Dosage: One tablet three times a day.

Supplied as aqua-colored, compression-coated tablets containing 15 mg. of Pro-Banthine (brand of propantheline bromide) and 5 mg. of Dartal (brand of thiopropazate dihydrochloride).

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*Lloyd's absorption-enhancing complex of vitamin B₁₂ (B₁₂ from Cobalamin Concentrate).

DOSE: One tablet per day.

SUPPLIED: Bottles of 50 tasty
"Cherro-Chew" tablets.

REFERENCES: 1. Chow, B. F.: Ger-

ontologia 2:213-221, 1958.

2. Chow, B. F., et al.: Am. J.
Clin. Nutrition 6:386, 1958.



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How's Your Consultation Etiquette?

I'm sometimes tempted to send a note to certain doctors to whom I refer patients for consultation. I want to say: "Don't forget that I'm referring Mr. Blank to you for your opinion only. I'll handle his treatment."

I've never sent such a note. But I often wish I had. I've also felt like writing—though I haven't done so—to certain colleagues who refer consultation cases to me. That note would explain what I think of inadequate work-ups, fuzzy instructions to the consultant, etc.

Consultation cases figure heavily in my practice. I get a great many; I refer nearly as many to colleagues. And I've become convinced that consultants and referring doctors alike need some brushing up on etiquette. Starting with the consultants themselves, let me discuss some

This experienced internist has some pertinent things to say about what constitutes good manners on both ends of the referral situation. Would you pass his test?

By Harold M. Tanning, M.D.

of the more glaring signs of thoughtlessness that I've encountered in recent months. (And remember that I'm speaking here of referrals *for consultation only*—not referrals for *treatment*.)

Some consultants have "appropriated" my patients.

When I refer a patient for consultation, I want nothing more than an opinion from my col-

THE AUTHOR, who writes here under a pen name, is an East Coast internist.

important new therapy in Peptic Ulcer

cessation of all symptoms and complete healing in 70 out of 78 cases as reported in Postgraduate Medicine (Oct.) 1959

"...chymotrypsin offers a new approach to the treatment of peptic ulcer."

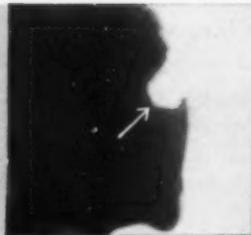
In 54 cases, most of them hospitalized, in which chymotrypsin (Chymar) was used in conjunction with other agents "All of the symptoms disappeared and complete healing of the ulcer occurred in 49 (90.7 per cent) of the 54 cases . . . Average time for cessation of symptoms . . . 6 days; for complete healing . . . 36 days; average follow-up period . . . 12 months. In 24 cases in which Chymar was used alone, "Cessation of all symptoms and complete healing occurred in 21 (87.5 per cent) of the 24 cases . . ." Average time for cessation of symptoms . . . 5.8 days; for complete healing . . . 24 days; average follow-up period . . . 25.5 months.

Conclusions: "Because of the excellent results obtained in 78 cases of peptic ulcer . . . I strongly recommend its use as a most valuable adjunct in the treatment of this disease."*

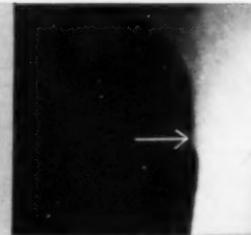
*Mozan, A. A.: Postgraduate Med. 26:542, 1959

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controls inflammation, swelling and pain



Pretreatment roentgenogram made on January 26, 1957 shows a large niche on the upper third of the lesser curvature.



Roentgenogram made on February 23, 1957 shows only a slight indentation on the lesser curvature.

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CONSULTATIONS

league—unless, of course, I state otherwise. In most cases, I distinctly ask for an opinion. Yet one man I used to refer to would think nothing of calling me after he'd seen my patient and saying: "I'd like to try him on such-and-such a drug for a week or two, just to see what happens. Is that O.K. with you?"

No, it wasn't O.K. I had to bite my tongue to keep from snapping: "All I want is your opinion of my diagnosis. I know three or four different ways of handling the therapy. Don't try to take over my case!" After a few such experiences, I struck the doctor's name off my list.

A similar gambit—one that "big" men in "name" institutions seem to like—goes like this: "If you don't mind, Harold, I'd like the patient to check back with me in six months or so. Just for evaluation, of course."

Well, I do mind. I don't need any Big Brother watching over me to make sure I don't foul up the case. Men who try this on me once never get a second chance. Nor do those who order lots of esoteric new tests that are medically unnecessary. I can't help



new dimensions
for control
of time
and fatigue

PLEASE SEE NEXT PAGE ▶

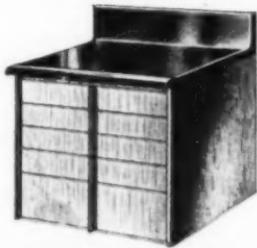
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CONSULTATIONS

suspecting such consultants of trying to impress the patient with their superior knowledge.

Some consultants have taken their own sweet time in reporting back to me.

The importance of a speedy report is so obvious that I shouldn't need to mention it. But I've been astounded at the number of consultants who think nothing of keeping a colleague in the dark for a week or two.

Not long ago, I couldn't resist telling one such man off. "I don't care how busy you were," I said. "If you couldn't send me a written report right away, you should have phoned me. How was I to know whether you'd even seen my patient? And what would I have told her if she'd asked me about your findings?"

Incidentally, it may not be *bad* manners to say nothing complimentary to the referring doctor about his work-up. But it's certainly *good* manners to compliment him, if you can. As many years as I've been referring patients, I still get a lift when a consultant tells me: "Those were fine films you took, by the way. They

Continued on page 153

Helps you
take the misery
out of menopause.....



... as hormones alone often don't do

**Fast-acting Milprem
directly relieves both
emotional dread and
estrogen deficiency**

Many physicians find that estrogen therapy is not enough for the woman who is also filled with anxiety by her menopause. Her emotional dread may make her so miserable that it becomes a real clinical problem.

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Dosage: One Milprem tablet t.i.d. in 21-day courses with one-week rest periods; during the rest periods, Miltown alone can sustain the patient.

Composition: Miltown (meprobamate) + conjugated estrogens (equine).

Supplied: Milprem-400, each coated pink tablet contains 400 mg. Miltown and 0.4 mg. conjugated estrogens (equine).

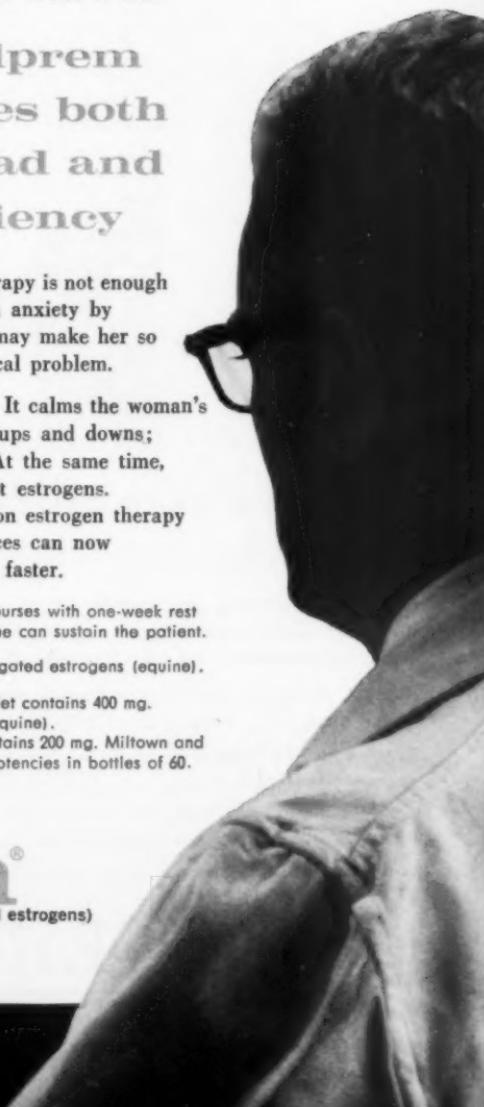
Milprem-200, each coated old-rose tablet contains 200 mg. Miltown and 0.4 mg. conjugated estrogens (equine). Both potencies in bottles of 60.

Literature and samples on request.

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the new concept for the treatment of allergic diseases.

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HOW'S YOUR CONSULTATION ETIQUETTE?

Showed me everything I needed."

Some consultants have ordered additional tests on their own.

Granted, consultants do get plenty of cases that aren't properly worked up. But that doesn't give them the right to do additional tests without the referring doctor's O.K.

Not long ago, I was called in on a complicated case of gastrointestinal upset on which the referring doctor had done an incomplete G.I. series. Minding my

manners, I phoned him. "Those pictures you sent me were good and clear," I said. "But I think we should go a little further and do small-bowel studies. Will you arrange for them, or do you want me to?"

As it turned out, he preferred to give the work to a radiologist friend. That was fine with me. But what if, like some doctors I know, I hadn't given him a chance to make the choice? It wouldn't have been fine with either of us.

First, if I'd done additional



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HOW'S YOUR CONSULTATION ETIQUETTE?

tests without discussing them with the referring doctor, he might well have inferred that I considered his work-up inferior. Secondly, I'd have been depriving another man of work that was rightfully his. And I might have lost a good source of referrals as a result of my insensitivity.

Of course, the referring doctor may not be able to do needed tests. For example, not many G.P.s are equipped to do air-contrast barium studies. But the consultant owes his colleague the courtesy of at least *asking* about the tests.

Some consultants have told the patient too much.

I expect to spend the next few years trying to convince one of my patients that she isn't on the verge of dying from hepatitis. She did have mild hepatitis when I referred her to a consultant, but it wasn't the main source of her trouble. Yet the consultant told her flatly that hepatitis was what she had. And she's a worrywart who never lets go of a diagnosis.

I know that the patient is entitled to learn a consultant's find-

ings from him. But I think we should use caution in following this rule. Unless I'm absolutely sure of the effect that bad news will have on a given patient who has been referred to me for consultation, I tell him something vague and let his own doctor make the full report.

How Referring M.D.s Err

So much for the bad manners of some consultants. Now let me comment briefly on what I consider good etiquette for referring doctors:

Have you ever had a strange patient walk in and say, "I'm Mrs. Blank. Dr. So-and-So said I should come see you"—when *Dr. So-and-So hasn't told you the patient was coming?* That's exactly what happened to me the other day. And not for the first time, either.

What was I to do? I had to phone Dr. So-and-So—with Mrs. Blank at my elbow—and ask him for a rundown on her case. I couldn't very well tell the patient to go away and come back later, could I?

Continued on page 158

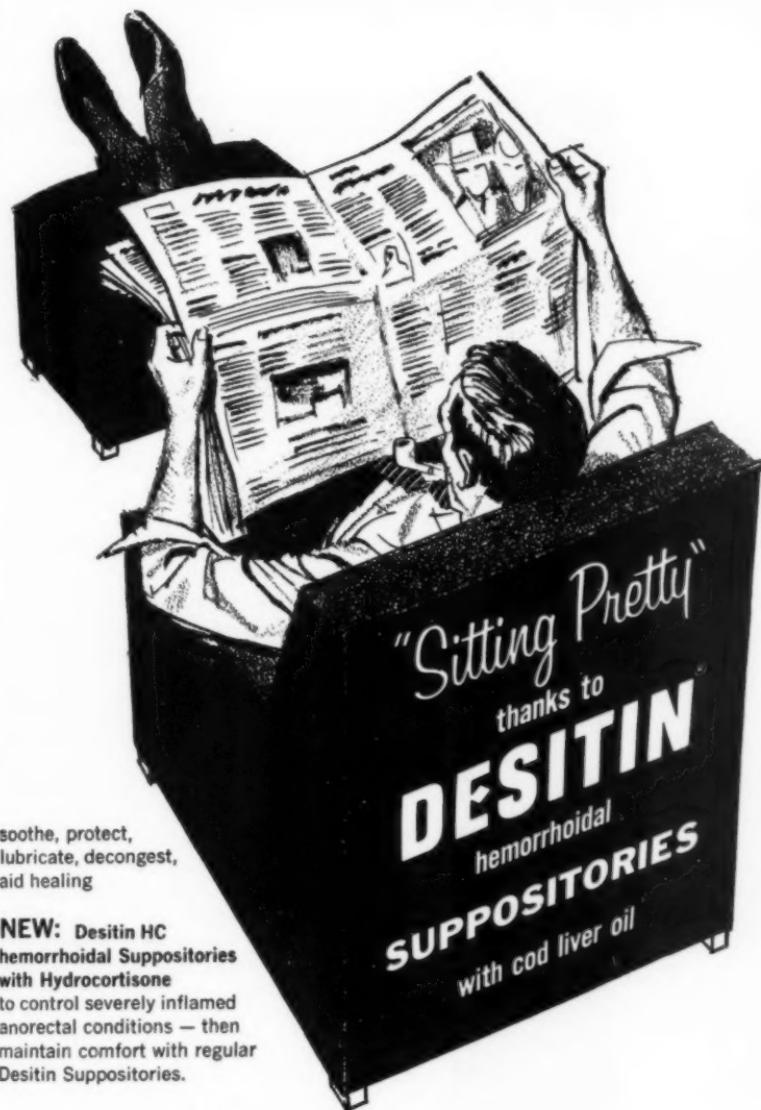
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158



soothe, protect,
lubricate, decongest,
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NEW: Desitin HC
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HOW TO GET MORE

IF YOU WANT TO FIND ...

the brand name of a drug

the manufacturer's name

essential product information; composition, action & uses, administration, dosage, precautions, contraindications, how supplied, literature available

a drug with a particular pharmacological action

a drug with a particular major ingredient

a drug with a particular therapeutic indication

generic name of a brand name drug

OUT OF YOUR 1960 PDR

AND YOU ALREADY KNOW...

HERE'S WHERE TO LOOK...

the manufacturer's name	Pink Section, Part II: Alphabetical Index by Manufacturers.
its generic name	Yellow Section: Drug, Chemical, and Pharmacological Index*
the drug's brand name	Pink Section, Part I: Alphabetical Index by Brand Names*
the drug's generic name	Yellow Section: Drug, Chemical, and Pharmacological Index*
the drug's brand name	Pink Section, Part I: Alphabetical Index by Brand Names*
the pharmacological action	Yellow Section: Drug, Chemical, and Pharmacological Index*
the major ingredient	Yellow Section: Drug, Chemical, and Pharmacological Index*
the therapeutic indication	Blue Section: Therapeutic Indications Index*
the drug's brand name	Pink Section: Part I, Brand name index. Generic name will be found under "Composition" in White Section.

*In the Pink, Yellow, and Blue Sections, the page number following the drug name refers to the page in the White Section where the drug is comprehensively described. If no page number is listed, the drug is not described in the White Section.

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CONSULTATIONS

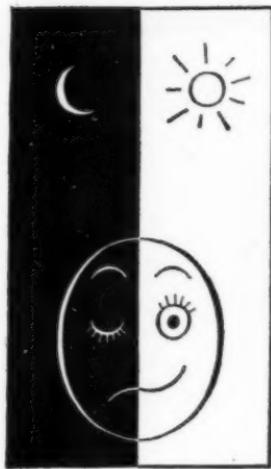
It seems to me that my colleague should have had the common sense to tell me the patient was coming and to send me her records. Moreover, he was at fault in not letting me know exactly what he expected from me. Did he want additional tests? Did he want me to assist in the therapy of the case? Or did he send me the patient only for my opinion?

Unless the referring physician tells me otherwise, I always assume he's simply after a second opinion. But I've often been wrong.

I also appreciate a doctor who does a good, thorough work-up on any consultation case he sends me. When someone doesn't, I have to call him up, explain as tactfully as I can what added work is needed, and ask him who is to do it. It's a task that's liable to cause friction, no matter how tactfully I handle it.

Consultation work should never cause friction. It should be a rewarding job for both the consultant and the referring doctor. When they mind their manners, it is. And the patient benefits accordingly.

END



Do you indicate
breaking
the long night fast
with nutritious

MEAT for breakfast

Meat is a logical nutritious "build-up". Far too many people, both adults and children, need to be reminded professionally that a nourishing breakfast is essential to help maintain good health.

Meat adds *Zest* to breakfast

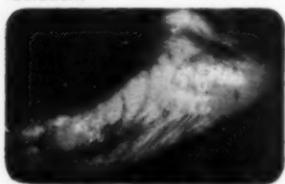
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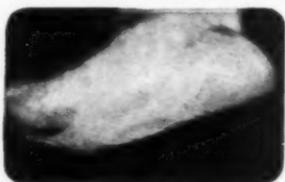
* MEMBERS THROUGHOUT THE NATION

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BEFORE: Severe, persistent dermatomycosis of several months duration.



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**WHITE'S VITAMIN
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with **Prednisolone**



AFTER: Same patient after two weeks therapy with Vitamin A and D Ointment with Prednisolone. Medication applied twice daily.

White's Vitamin A and D Ointment is now available **with Prednisolone** (0.5 per cent) in a lanolin-petrolatum base. The local anti-inflammatory and anti-pruritic effects of prednisolone augment the healing, soothing and protective effects of White's Vitamin A and D Ointment. **For dermatoses caused by thermal or chemical irritants, common allergic skin disorders and nonspecific pruritus ani and vulvae.**

Supplied in 10 and 25 Gm. tubes. White Laboratories, Inc.,
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The Best Time to See Difficult Patients

If they just can't bear waiting their turn, or if they just can't stop talking, why not have special times for seeing them? It's worth the time and trouble, says this doctor

BY MARION WHITE, M.D.

How do you handle those few inevitable patients who—you know from experience—are bound to be troublesome?

Do you make advance arrangements for the complainers and the time-wasters? Or do you just take them as they come and hope they won't wreck your schedule, your aide's disposition, and the equanimity of your other patients?

I've found from sad experi-

ence that a patient who has turned my day upside down once is likely to do so again. For a long time I simply gritted my teeth and bore up under the strain. My nurse used to say at the start of the morning: "Now, Doctor, you'll hit this snag at 10 o'clock, and after that it should be smooth sailing."

The "snag" surely never recognized herself as such. More

Continued on page 164

THIS ARTICLE has won one of the 1960 MEDICAL ECONOMICS Awards for its author, a West Coast practitioner who writes here under a pen name.

control—at every stage of anticoagulant therapy—certified before introduction by five years of intensive clinical study and published reports¹⁻⁷

rapidity of induction and recovery time—Prothrombin levels usually fall to 50 per cent in 6 hours, to therapeutic range of 15 to 30 per cent in 48 to 72 hours—Normal limits restored in 12 to 48 hours by stopping the drug.

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Well tolerated and relatively non-toxic no nausea and vomiting, diarrhea, proteinuria, agranulocytosis or leukopenia yet observed—chromaturia infrequent and transient.

Single daily dose convenience

Packaging—MIRADON Tablets, 50 mg., bottle of 100.

predictability of initial and maintenance dosages—One dose usually produces a “predictable fall in prothrombin activity.”¹—In day-to-day use “a single daily dose produces striking uniformity of response....”⁶—“Results are reproducible.”²

reversibility of anti-coagulant effect—Safe prothrombin levels restored in 5 to 8 hours with vitamin K.⁷—“The anticoagulant effect can be restored rapidly by remedication.”³—Drug resistance minimal.

Bibliography: (1) Lange, K.; Mahl, M. M.; Perchuk, E., and Enzinger, J.: Anisindione: A New Improved Anticoagulant, Scientific Exhibit, Presented at Annual Meeting, A.M.A., New York, June 3-7, 1957. (2) Blaustein, A.: New York J. Med. 58:701, 1958. (3) Lange, K., et al.: Am. Heart J. 55:75, 1958. (4) Paul, H. A.; Arscott, P. M.; Koppel, J. L., and Olwin, J. H.: Surg., Gynec., & Obst. 108:605, 1959. (5) Olwin, J. H.; Arscott, P. M., and Koppel, J. L.: Geriatrics 13:773, 1958. (6) Kellaway, G.; Brie, M. J. 2:899 (Oct. 11) 1958. (7) Connell, W. E., and Mayer, G. A.: Canad. M. A. J. 80:785, 1959.

For complete information on indications, dosage, precautions and contraindications consult the Schering Statement of Directions.

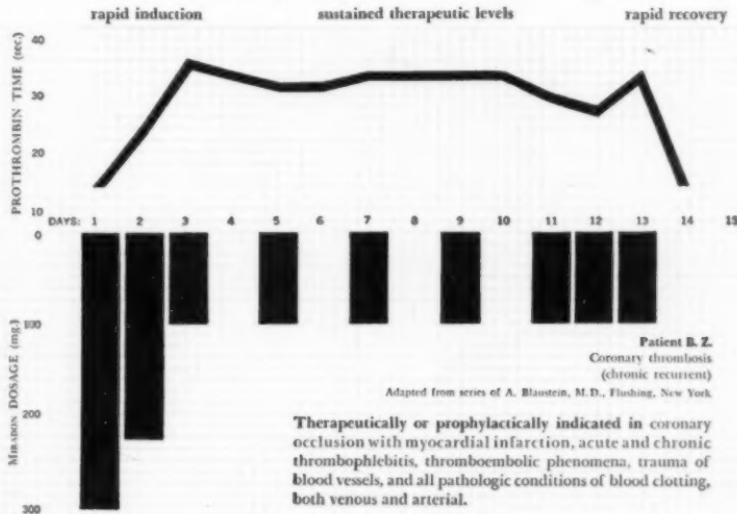
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Miradon...“is an excellent oral anticoagulant, of which we are now making extensive use in both acute and long-term anticoagulant therapy.”⁷

Miradon[®]

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new oral prothrombin depressant



Patient B.Z.
Coronary thrombosis
(chronic recurrent)

Adapted from series of A. Blaustein, M.D., Flushing, New York.

Therapeutically or prophylactically indicated in coronary occlusion with myocardial infarction, acute and chronic thrombophlebitis, thromboembolic phenomena, trauma of blood vessels, and all pathologic conditions of blood clotting, both venous and arterial.

WHEN TO SEE DIFFICULT PATIENTS

often than not, she had been my patient for years, and we were genuinely fond of each other. My problem was that such a patient's visit so confounded the day's schedule that it never quite returned to normal.

Then it occurred to me that I and my staff weren't the only ones who suffered from my grin-and-bear-it handling of the dif-

ficult people on my schedule. They took some of my time and attention that belonged by right to other patients. And just as a troublesome patient's visit was frustrating to me, it no doubt also left the patient feeling dissatisfied.

So about a year ago I decided to take special measures with es-

Continued on page 168



"After my last set of shots, she had mastitis for two weeks."

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He's got a tiger's appetite!"



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sustained-action hydrochlorothiazide "Bristol"

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... a superior foundation drug (hydroflumethiazide) for an antihypertensive regimen . . . often the only drug required for effective therapy.^{1,2}

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... helps to restore "dry weight" while lowering blood pressure.¹

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... prompt sodium excretion,¹⁻⁶ with "a duration of at least 18 hours" on a single 50-mg. tablet.¹

... less potassium and bicarbonate excretion or pH change than with chlorothiazide or hydrochlorothiazide.^{1,4,5,7,8,9,11,12}

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DOSAGE: Usually 1 tablet daily. Full information in package insert.

SUPPLY: Scored 50-mg. tablets; bottles of 50. Syrup, containing 50 mg. per 5-ml. teaspoonful; bottles of 8 fl. oz.

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WHEN TO SEE DIFFICULT PATIENTS

pecially bothersome patients—for the sake of everybody concerned, I would try separating difficult patients as much as possible from the normal routine of my working day.

Special Appointments

Now each patient who's expected to be a problem gets an appointment either quite early or very late. Exactly how I schedule him depends on his particular penchant for disrupting things. Let me explain how I tag and schedule these problem patients. You may be able to profit from my example.

First, there's the individual I call "an in-and OUTER." If permitted, she (it's usually a woman) will bob in and out of this room and that, distracting me and my aides in our work with other patients. She's received and is ushered through the hall; but en route to the consultation room she spots the doctor and immediately starts the story of why she's here, etc.

She is moved along to a consultation room. But in a few seconds she's back in the hall, hav-

ing decided to get the magazine she left in the reception room. Now she encounters the doctor again or the nurse, and once more starts a recital of complaints. Or she asks, "Do you think I should have brought my daughter Annie, too? Her grandmother thought she was looking pale."

She is again maneuvered to a consultation room—but there's more to come. She's back a second time. Now she must use the phone to call her neighbor to tell her to watch for the postman, etc., etc.

It Builds His Practice

Yet this type of patient is often one of my best boosters. Frequently she'll refer her relatives and friends to me. She's well worth a special appointment—and that's what she now gets. I try to schedule an in-and-outer before the other patients arrive, either mornings or afternoons. Actually, she's slated to arrive fifteen minutes before I do. Thus, before there's much traffic in the office, she's cared for and on her way.

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WHEN TO SEE DIFFICULT PATIENTS

Next, there's the impatient type. I'm sure you have some such patients: the pacers and the "how much longer?" individuals. Seat one of them in a crowded waiting room, and he generally succeeds in making everybody else as nervous and impatient as he is.

So I schedule the known impatient waiters for quite early in the morning or equally early in the afternoon. Then I can attend to them promptly, since my schedule hasn't yet had time to run seriously behind.

The Time-Waster

Lastly, I make special appointments for patients who are in the habit of taking more time than average. For example, I recently gave the last appointment of the day to a woman I'll call Mrs. Williams. She was bringing her little boy in; and the moment they got to me, she began jabbering:

"Jimmy was still all right on Sunday. I'm sure he was, because that was the day we didn't get to go to his Aunt Mildred's because we found out we had to

go to Beach City to get the boat space rented. We did think he seemed a little tired on the way down, but it didn't concern us much at the time because he'd had his swimming lesson the afternoon before . . ."

She's All Wound Up

I still didn't know what was troubling Jimmy. On she went: "Now, Jimmy usually likes only noodle soup or cottage cheese for lunch, but if you think it would be easier on his stomach, I could . . ."

Sad to say, in the days before I started the special-appointment plan, I might well have interrupted irritably. But now she can have all the time she needs. The other afternoon I didn't feel pressed, for it had been planned that way. I let her talk herself out.

As the interview ran on and on, I listened patiently while she discussed virtually all her family problems. And when she showed signs of running down, I inquired politely: "Now, is there anything else?"

Perhaps you think I go over-

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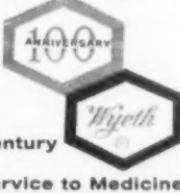
The benefits that this system confers upon you, your nurse, and your patients are clear:

1. Benefits to you: With the TUBEX system you can give injections quickly and efficiently with a minimum of preparation. The pre-filled cartridge and needle units require no sterilization or sharpening; are ready to go at a moment's notice. They fit easily and conveniently into your bag and are readily stored and inventoried in the office. Medications available in TUBEX form are many and varied; for others, empty, sterile TUBEX units can be used. *Cost is surprisingly modest.*

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3. Benefits to your patients: Since cartridge-needle units are used just once, the danger of cross-contamination (transmittal of serum hepatitis, for example) is eliminated. Accurate doses guard against the danger of accidental overdoses. The pre-sharpened, single-use needles assure relatively painless injections, encourage patient cooperation.

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WHEN TO SEE DIFFICULT PATIENTS

board in granting so much time to a compulsive talker like Mrs. Williams. But there's a method in my generosity. It pays off by saving time in the long run. You see, I've discovered that most such pent-up patients change their ways after having one or two ventilating sessions. They come to the point faster. They're less likely thereafter to clog up the schedule.

I believe this is because I'm no longer urging them, in one way or another, to hurry. So my time given ungrudgingly at a slack hour is regained later.

Is It Fair?

But you may object in principle to my way of handling troublesome patients. "Why should a doctor reward these demanding types with special handling?" you may argue. "It doesn't seem fair to the majority of patients who *don't* expect red-carpet treatment."

On the contrary, I'd say the only way to be fair to everyone is to make special arrangements for handling your troublesome patients.

First, as I've said, they're often your best boosters. If you cater to their whims, they're likely to show their gratitude by sending relatives and friends to you.

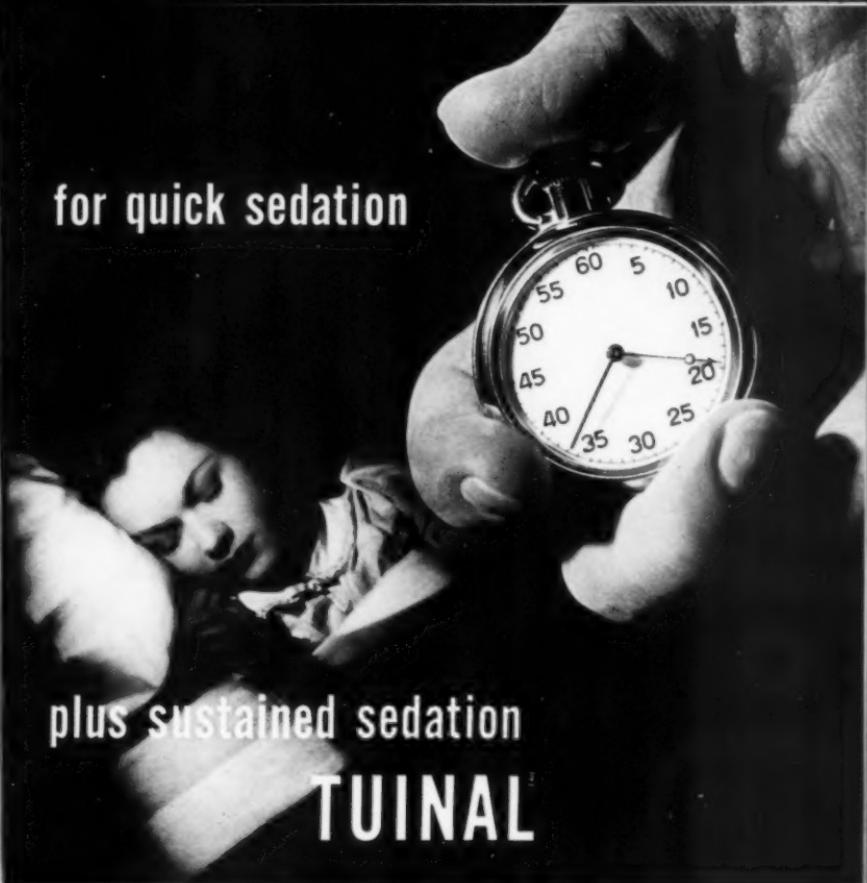
It's a Necessity

Secondly, the troublesome patient for some reason feels in need of the special handling he demands—while his more cooperative neighbors obviously don't feel that need. It's good medicine to grant the superindividualist on your patient-list the attention he craves. It's part of the treatment.

Lastly, you may have noticed that the troublesome types have one thing in common: They're a potentially disturbing influence on other patients.

That's my strongest reason for recommending that you give special appointment periods to the bothersome minority. Schedule them when your waiting room is likely to be empty—and see them punctually when they arrive. Then you can at least prevent their making *public* nuisances of themselves.

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1. Maerz, J.C.; Lee, H.G., and Hunter, H.H.: Treatment of Anxiety and Depressive Reactions: Special Requirements of Working Patients, report accompanying scientific exhibit at the Clinical Meeting of the American Medical Association, Dallas, Dec. 2-4, 1959.

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Changes Coming in the Income Tax Laws?

**Broad-scale reforms are in the wind.
Here are some of the suggestions that have
attracted the most attention**

BY HOBART ROWEN

Sooner or later—though probably not as soon as you'd like—today's jerry-built income tax laws must undergo wholesale reform. That's increasingly apparent as public pressure builds up for eliminating the special tax treatment now enjoyed by some segments of the population and some kinds of income.

Broad-scale tax revision should permit a reduction in the present 20 to 91 per cent tax rates on individual income; the

rates will probably go down to something like 10 to 60 per cent, predicts Chairman Wilbur Mills of the House Ways and Means Committee. Other experts agree that an upper limit of around 60 per cent for the future is wholly realistic.

How will this important basic change be achieved? Mostly by a drastic curtailment or elimination of special tax "havens."

True, Congress probably won't make important revisions in the

THE AUTHOR, a veteran Washington correspondent, specializes in economic news. His first-hand reports from Capitol Hill have appeared in a number of national periodicals.

CHANGES COMING IN INCOME TAX LAWS?

tax law during its current election-year session. But if it doesn't do so in 1960, it will have to come to grips with the problem soon thereafter. A straw in the wind was the agreement in February by both Democratic and Republican members of Congress' Joint Economic Committee that tax reform is necessary.

What shape is such reform likely to take? How will it affect you, as a tax-paying physician? The Mills committee—which initiates all tax legislation—held five weeks of hearings on the subject last winter. Among the suggestions that attracted the most attention were proposals to:

1. Withhold taxes on interest and dividend payments.

In 1957, taxpayers failed to report an estimated \$1 billion in dividends and \$3.5 billion in interest. Because the Administration wants to give the voluntary system one more whirl, the Internal Revenue Service has arranged with banks, corporations, and others to enclose "reminders" with dividend or interest payments. But if there isn't quick

improvement in voluntary reporting, a withholding system of some kind is a good bet for the near future.

2. Reduce the tax benefits to investors in natural resources.

Those who invest in natural resources are now getting such a tax break that they're sometimes able to recover many times their entire investment in a comparatively short period. Reason: huge "depletion allowances" that permanently exclude from taxation large amounts of revenue.

It's estimated that if the Government limited the "depletion allowance" for oil and gas to the period necessary to recover the cost of each well, it would recoup about \$1 billion to \$1.5 billion in taxes annually. If it reduced the depletion rate to 15 per cent for the giant firms, it would pick up \$400,000,000.

Any such change wouldn't affect the way you fill out your income tax return, of course—unless you actually owned an oil well or part of one. But if you were an oil investor, it probably would result in a drop in profits

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sciatica

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"Side effects were conspicuous by their rarity."¹⁵

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A single low-dosage drug providing therapeutic benefit at reasonable cost...contains no unnecessary added ingredients that increase cost...requires no extended-action tablet structure for prolonged effect.

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The value of BONINE as an antinauseant has been well documented and is supported by six years of successful clinical use.¹⁻¹⁰



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CHANGES COMING IN INCOME TAX LAWS?

for the company you had your money in—and thus would mean lower dividends for you.

A large bloc in Congress is continuing to push for early changes in oil depletion allowances. But these legislators concede privately that they don't have much chance at this session.

3. Remove the tax exemption on the interest from municipal bonds.

It's estimated that in 1957 individuals received about \$600,000,000 in tax-exempt interest on municipal bonds, as state and local government issues are usually called. As highway and other local construction projects increase in number, this sum will grow larger.

In effect, the exemption provides a subsidy for local government operations. But it also provides corporations and high-bracket individuals with a tax windfall. For example, one authority figures that a man with a net taxable income of \$32,500 would have to find himself an investment yielding 11.4 per cent in order to keep as much after

taxes as he gets from an untaxed 4 per cent municipal bond.

Proponents of a revision in the law argue that taxing the interest on municipal bonds would stimulate a flow of investment funds out of municipal bonds into risk-taking ventures and would thus promote economic growth. Direct subsidies could be given the state and local governments concerned, they say.

But prospects for such a change are small in the foreseeable future. Says a House committee staffer: "If we tried it, there'd be so many local officials down here that we couldn't get a stenographer into the hearing room."

4. Narrow the definition of capital gains.

As almost every taxpayer knows, capital gains are taxed at a maximum rate of 25 per cent. What increasingly concerns the legislative tax reformers is not so much this rate as the question of what should qualify for capital-gains treatment. For instance, timber and coal royalties are taxed at capital-gains rates. So

Continued on page 187

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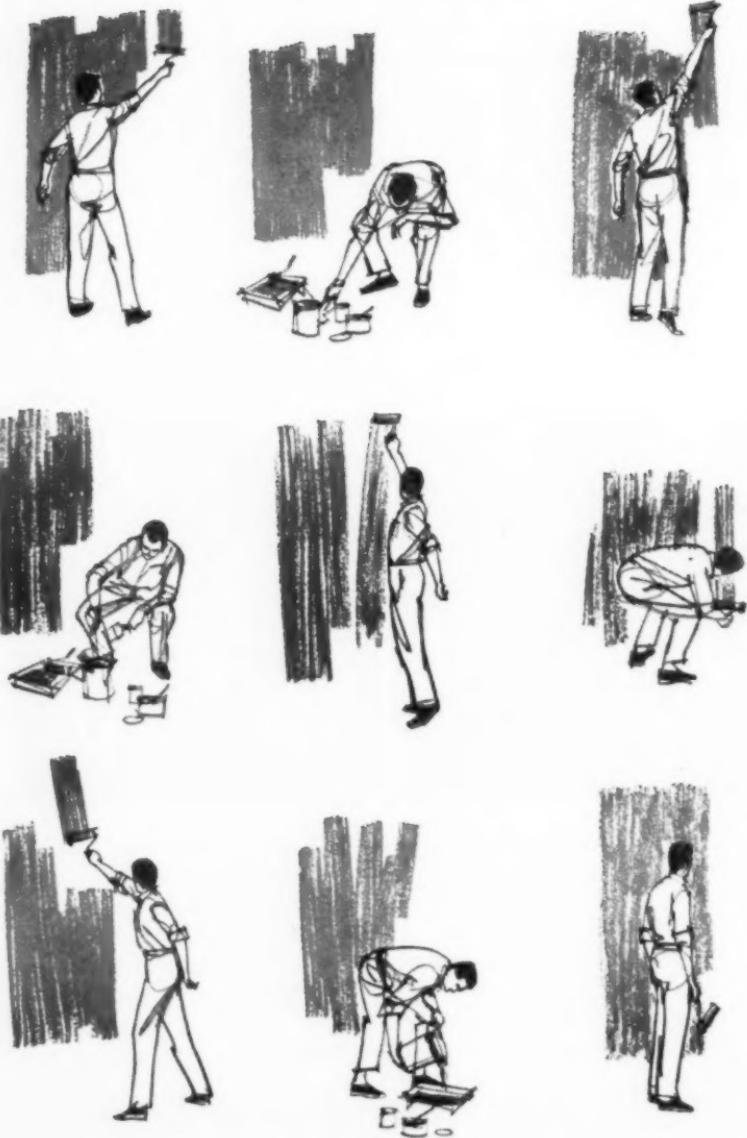
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CHANGES COMING IN INCOME TAX LAWS?

are gains on stock options, although there's no real risk of capital and often no investment at all.

The direction of eventual reform probably lies in tighter definitions and a narrowing of the differences between capital and normal gains by raising the 25 per cent figure and lowering the regular scale. But these changes, too, are apparently to be far in the future.

5. Remove the dividend credit.

In 1954, Congress provided investors in stock with a \$50 exclusion for dividends and a credit against taxes equal to 4 per cent of dividends received in excess of \$50. In 1957, this arrangement cost the Government roughly \$280,000,000 for the exclusion and \$317,000,000 for the credit. Sixty-six per cent of the credits that year went to taxpayers with incomes over \$10,000, 36 per cent to those with incomes over \$50,000.

The Democrats in Congress have opposed this provision of the law with great regularity. Last year, the Senate voted to repeal it. But the House wouldn't

go along. The same pattern is probable this year.

6. Tax interest on life insurance policies.

Those who invest in life insurance now get preferential treatment, because there's no tax on the interest accumulations on their policies. Nor are the pro-



"Come now, Clancy... my diagnoses check out more often than that!"

CHANGES COMING IN INCOME TAX LAWS?

ceeds taxable at death. The amount of such untaxed interest was estimated at \$1.1 billion in one recent year.

None the less, Congress isn't likely to vote a tax on such interest. What it may eventually do is to alter the tax treatment of life insurance companies themselves.

7. Limit personal deductions.

Bit by bit, the tax code has allowed increasing deductions for personal expenses wholly unrelated to the production of income. In 1956, taxpayers deducted a total of about \$31 billion under such provisions.

Any reforms would probably sharpen the limitations on personal-expense deductions. For example, the parts of the code dealing with casualty losses might be rewritten so that such losses would be handled like medical expenses, with a minimum that couldn't be deducted and a maximum that could.

Much attention was also given during the Mills committee hearings to the favored position of individuals who own their own homes. Homeowners can now de-

duct their mortgage interest and real property taxes; and they pay no taxes on the "imputed income" (or net rent equivalent) of the homes they themselves occupy. But there's virtually no chance that Congress would go along with a reform in this realm.

Suggestions for disallowing deductions for state and local sales and excise taxes may get more consideration—but not before 1961.

8. Eliminate low-income preferences.

Under rulings by the Internal Revenue Service, elderly taxpayers have an exclusion for their Social Security income. This benefit is in addition to the extra \$600 old-age exemption and the higher medical expense allowances. More than a few witnesses at the Mills committee hearings advocated changes in these provisions. "But if Congress ever decided that Social Security payments should be made taxable, there'd be immediate pressure for higher Social Security payments," says an insider.

More►



"... which antacid? Rorer's Maalox. Excellent results,
no constipation plus a pleasant taste that patients like."

MAALOX® an efficient antacid suspension of magnesium-aluminum hydroxide gel offered in bottles of 12 fluidounces.

TABLET MAALOX: 0.4 Gram (equivalent to one teaspoonful), Bottles of 100.

TABLET MAALOX No. 2: 0.8 Gram, double strength (equivalent to two teaspoonsfuls), Bottles of 50 and 250.

Samples on request.

WILLIAM H. RORER, INC., Philadelphia 44, Pennsylvania

CHANGES COMING IN INCOME TAX LAWS?

Another important tax concession to lower-income groups is that many "fringe" benefits won through collective bargaining are tax-free. That's one reason why labor has put increasing emphasis on winning fringes as

part of wage "packages." Yet at the present time Congress is far from any serious study of this problem.

* * *

The above areas of tax reform are the main ones now under

What's That on Your Walls?

*If it's paint, you may do better by
using one of the more modern surfaces*

By Sally and Sidney Liberman

Next time you redecorate your office, consider the newer wall surfacings. They cost more than paint at first, but last a lot longer. Five we recommend are ceramic tile, laminates, vinyl, washable wallpaper, and wood paneling. Facts about each are given opposite. Whatever your preference, here are some tips:

1. The lighter the color, the larger the room appears.
2. Walls the same color as the woodwork make rooms seem larger.
3. Trick or novelty surfacing patterns soon become tiresome.
4. Any of the recommended surfacings will last a long time, so be sure you're sold on it.

THE AUTHORS are a New York City team of interior and industrial designers.

discussion in Washington. Chairman Mills and his staff aren't hopeful of much *near-term* success in pushing through basic changes in the law. But they expect progress to be made within the next few years.

An enormous amount of income completely escapes being taxed under the present tax laws. And this is why most tax authorities believe that the tide must eventually turn toward reform.

END

Wall Surfacing	Best Kind And Cost	Characteristics	Where Usable
Ceramic tile	Satin glazed; \$1.30 to \$2.25 per sq. ft., including labor	Very durable; stain-resistant; easy to clean	All rooms
Laminates (such as Formica or Micarta)	1/16" gauge; \$1.80 to \$2.50 per sq. ft., including labor	Very durable; holds little dust; can be cleaned with damp cloth	All rooms
Vinyl	Supported vinyl, medium weight or heavy; 95 cents per sq. ft., including labor	Resists abrasion; color-fast in usual conditions; smooth surface doesn't hold dust	All rooms except where hot equipment is used
Washable wallpaper	Plastic coated; \$4 to \$10 per roll plus labor. One roll covers 30 to 40 sq. ft.	Outlasts paint. If patterned, tends not to show dirt	All rooms except where there's moisture
Wood paneling	Prefinished; 65 cents per sq. ft., including labor	Needs only dusting and waxing every 4 to 5 years	Best limited to consultation rooms—scratches and stains easily

END

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SAFE • EFFECTIVE ANTIEMETIC

in—

- motion sickness
- vestibular disturbances
- postoperative vomiting
- febrile illness in children
- drug therapy
- gastroenteritis

**PREVENTS OR QUICKLY RELIEVES
DIZZINESS • NAUSEA • VOMITING**

and—

- is free of hypotensive action
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TABLETS • INJECTION • SUPPOSITORIES

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BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, New York

Who Should Finance Your Car . . .

a Bank, a Dealer, or You?

These facts about the true costs of credit and bank loans will help you choose the method that's easiest on your pocketbook

By Albert S. Wall

If you're like most doctors, you shop carefully when the time comes to buy a new car. Perhaps you even examine and compare the various features of every model in your price range. You want to be sure you don't get a lemon.

But do you give the same thought to financing your pur-

chase? If you don't, you may be wasting money. Though the alternatives in car financing are few, their costs vary widely. So the financing arrangement you choose might also turn out to be a lemon.

How so? Because of hidden interest charges—interest you have to pay above and beyond the figure that's quoted you. It's easy to mistake the "nominal" 6 per cent you might pay on a credit loan for the *true* interest. (True annual interest involves the *full* use of a certain sum for a year. For instance, if you borrow \$100 at a true 6 per cent rate, you repay \$106 a year later.)

"Nominal" interest isn't literally interest; it's a carrying or

Continued on page 195

THE AUTHOR, who is on the staff of a national news magazine, has written many articles on cars for well-known periodicals.

the means



seborrheic dermatitis - 2 years duration

Many dermatoses, often complicated by bacterial and fungal infections, show a dramatic response to Mycolog therapy. Mycolog offers total management of a wide range of dermatologic disorders such as intertrigo, infantile eczema, paronychia, anogenital pruritus and other dermatoses. This is especially true when monilial or other secondary infections are apt to de-

velop. Because its properties derive from the joining of a corticoid, an antibacterial combination and an antifungal-antibiotic, Mycolog exhibits impressive anti-inflammatory, antiallergic, antibacterial, antifungal, antipruritic action. It is well tolerated, readily acceptable to the patient and assures a decisive, safe, and rapid clinical response.

KENALOG®, *PLASTIBASE®*, *SPECTROCIN®*, *HYCOSTATIN®* AND *MYCOLOG®* ARE SQUIBB TRADEMARKS.

es to the end



clear—in 12 days

SQUIBB



*Squibb Quality—the
Priceless Ingredient*

ive from
bacteria
tibiotic,
inflamm-
anti-
well
patient
apid

Supply: Mycolog Cream and Ointment, 5 Gm. and 15 Gm. tubes. *Also Available:* Kenalog Cream, 0.1%—5 Gm. and 15 Gm. tubes. Kenalog Lotion, 0.1%—15 cc. plastic squeeze bottles. Kenalog Ointment, 0.1%—5 Gm. and 15 Gm. tubes. Kenalog-S Lotion, 7.5 cc. plastic squeeze bottles. Kenalog-S Ointment, 5 Gm. and 15 Gm. tubes. Kenalog-S Cream, 5 Gm. and 15 Gm. tubes. *New:* Kenalog Spray, 50 Gm. and 150 Gm. containers of 3.3 mg. and 10 mg. triamcinolone acetonide, respectively.

Mycolog

Squibb Triamcinolone
Acetonide (Kenalog)

Neomycin—Gramicidin (Spectocin) and
Nystatin (Mycostatin) in Plastibase

FINANCING YOUR CAR

time charge. And, in installment loans, you not only begin to pay the nominal interest after the first month, but also the principal itself. You continue doing so month after month until the loan is paid off. Thus the actual money at your disposal keeps shrinking, although the carrying charge remains the same.

Which is why the *true* carrying charge on an installment loan usually runs about twice the stated charge.

There's little doubt, then, that it's often best to pay cash for a new car. You do forgo interest on any money that you must withdraw from a savings account, or that you get by converting bonds into cash. But the amount you lose is seldom as much as what you'd have to pay on an installment loan.

What if you don't have the money in the bank or in bonds? What if your surplus funds are

Continued on page 200



"Mrs. Jones wants to know, is it cold enough to wear a coat over her suit?"



greater
activity

unsurpassed G.I.
toleration

sustained
peak action

extra-day protection
against relapse

NOW...THE EXTRA BENEFITS OF BROAD-SPECTRUM

DECLOMYCIN®

Demethylchlorotetracycline Lederle

IN THE NEW,
CHERRY-FLAVORED **SYRUP**

75 mg./5 cc. tsp., in 2 fl.
oz. bottle—3-6 mg. per lb.
daily in four divided doses

LEDERLE LABORATORIES

a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York



improve coronary
blood flow in angina
and postcoronary
patients with

PERITRATE® 20 mg.



- **a proven drug**—supported by extensive clinical experience in the last ten years
- **selective physiologic action**—unlike most nitrites, dilates coronary vessels principally, with minimal peripheral effects, so that coronary blood flow is increased with no significant change in blood pressure or pulse rate
- **exceptionally safe for prolonged use**—virtually eliminates nitrate headaches—tolerance has not been reported
- **effective in mildest to severest angina pectoris**—reduces frequency and severity of anginal attacks in 4 out of 5 patients; increases exercise tolerance, lowers nitroglycerin dependence, and improves ECG findings
- **ideal in postcoronary convalescence**—*helps establish and sustain collateral circulation* to reduce the extent of myocardial damage, to encourage natural healing and repair, to minimize ensuing anginal attacks
- **adaptable prophylaxis**—available in several formulations to meet the individual requirements of patients with coronary artery disease: *Peritrate 20 mg., Peritrate with Phenobarbital, Peritrate Sustained Action and new Peritrate with Phenobarbital Sustained Action* for 24-hour protection of the apprehensive cardiac patient, with just 2 tablets daily



MORRIS PLAINS, N.J.

FINANCING YOUR CAR

tied up in a highly profitable venture like real estate or growth stocks? Then it may be best *not* to pay cash for the car. Keeping the money at work might not only pay for the loan but also net you some profit.

Here's a good rule of thumb: Don't convert into cash any investment that's likely to bring you 12 per cent or more a year in interest and appreciation combined. At that rate, it's earning at least as much as the annual cost of a car loan.

If you decide against paying

cash, a bank loan is probably your best bet. Let's say that the price of the car you want to buy is \$4,000. You're asked to make a down payment of \$1,400. With any luck, the trade-in value of your old car will cover this sum. So you need a \$2,600 loan.

Banks are legally allowed to discount their finance charges in advance. In other words, they may subtract the charges from the face value of the loan. So in order to borrow \$2,600 at a 4.75 per cent discount rate (a typical figure), you'd have to sign a note

An advertisement for Sigmagen. It features a black and white photograph of a person's hands typing on a typewriter. The hands are shown from the side, with one hand on the keyboard and the other holding a piece of paper. The background is dark and out of focus. The text "hand-it is" is written in a large, bold, sans-serif font. Below it, in a smaller font, is the word "yes, any rheumatic 'itis' calls for". Underneath that is the brand name "Sigmagen" in a large, stylized, italicized font. In the bottom right corner of the ad, there is a signature that reads "Schering".

"hand-it is"
yes, any rheumatic "itis" calls for
Sigmagen

Schering

BB-J-458

200 MEDICAL ECONOMICS • MAY 9, 1960



preferred
for
the
treatment
table

**because Neo-Polycin Ointment
helps clear
topical infections
promptly**

Neo-Polycin® provides neomycin, bacitracin and polymyxin, the three antibiotics preferred for topical use because this combination is effective against the *entire* range of bacteria causing most topical infections...has a low index of sensitivity...and averts the risk of sensitization to lifesaving antibiotics, since these agents are rarely used systemically. And Neo-Polycin provides these three antibiotics in the unique Fuzene® base, which releases higher antibiotic concentrations than is possible with grease-base ointments.

Each gram of Neo-Polycin contains 3 mg. of neomycin, 400 units of bacitracin and 8000 units of polymyxin B sulfate in the unique Fuzene base. Supplied in 15 Gm. tubes

PITMAN-MOORE COMPANY, DIVISION OF ALLIED LABORATORIES, INC., INDIANAPOLIS 6, INDIANA

*Unexcelled Effectiveness
and Acceptability*

for VAGINITIS

trichomonal
monilial
bacterial (*nongonococcus*)

MILIBIS®

Vaginal
Suppositories



Average dosage: 1 suppository inserted every other night before retiring, for 10 doses.



Supplied in
boxes of 10 with
plastic applicator.

Sanitary • Assures correct placement.

Winthrop LABORATORIES
NEW YORK 18, N.Y.

Milibis (brand of glycolbromate),
trademark reg. U.S. Pat. Off.

202 MEDICAL ECONOMICS • MAY 9, 1960

FINANCING YOUR CAR

for a larger sum of money. The exact amount would depend on whether the loan was to be paid back in twelve, twenty-four, or thirty-six monthly installments.

Thus, you might take out a one-year loan for \$2,736 (twelve payments of \$228 each); or a two-year loan for \$2,880 (twenty-four payments of \$120 each); or a three-year loan for \$3,024 (thirty-six payments of \$84).

Note that your carrying charges would be slightly larger than the basic discount rate calls for. Reason: Bank-loan charges normally include small extra payments for a life-insurance provision.

Note, too, that the *true* annual interest on any such plan would range from 10 to nearly 11 per cent a year. That's because of the way the total cash at your disposal would diminish through the months. On the three-year plan, you'd pay out a total of about 33 per cent in true interest over the thirty-six months.

Financing Through a Dealer

What if you find it inconvenient to get a bank loan? Because
Continued on page 206

since 1943

Wyeth

has provided the physician continuously
with
new and better forms of penicillin



NOW

Wyeth announces

TABLETS

DARCIL

a new, high-performance penicillin molecule

Remarkably stable in gastric acid

Efficiently absorbed

Peak blood levels rapidly induced

Highest oral penicillin blood levels

Highest urinary excretion

Lethal to many Staph. strains

Safer oral route reduces allergenicity hazard

provides the physician with an added measure of assurance

provides the patient with an added measure of protection

DARCIL *clinically effective*

DARCIL (phenethicillin potassium) is *more rapidly* and *more completely* absorbed from the gastrointestinal tract than any other type of penicillin molecule. As a result, tissues are more likely to be supplied with adequate penicillin, despite individual patient-variation in the absorption of drugs. Blood concentrations of DARCIL directly reflect dosage levels, permitting adjustment of dosage to severity of infection.

*Many strains of *Staph. aureus* susceptible*

Morigi *et al.*¹ administered phenethicillin potassium to 47 patients with a variety of bacterial infections caused by penicillin-susceptible organisms. Clinical entities included: acute tonsillitis, acute pharyngitis, otitis media, otitis externa, cellulitis, furunculosis, carbuncle, pyoderma, impetigo, thrombophlebitis, and Vincent's angina. Dosage was 250 mg. q.i.d.; average duration of therapy, 3 to 6 days.

Twenty strains of *Staph. aureus* were isolated from pre-therapy cultures; 19 were highly susceptible to phenethicillin potassium *in vitro*; one was resistant. Seven strains of beta-hemolytic streptococcus were also isolated and found susceptible.

Of the 47 patients treated, 38 were cured, 6 improved, and 3 unresponsive. No evidence of intolerance or allergic phenomena was observed (true also in the 210 human subjects utilized for laboratory studies).

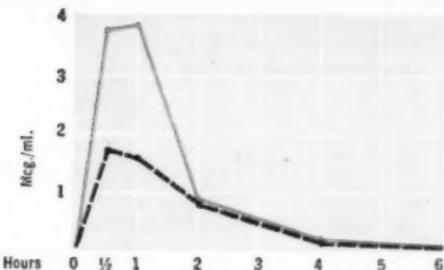
Prompt regression of symptoms

Cronk *et al.*² report prompt regression of symptoms and disease in all cases of bacterial infections caused by organisms susceptible to penicillin. Successfully treated were 38 patients representing cases of tonsillitis, gingivitis, otitis media, pneumonia, peritonsillar abscess, gonorrhea, cellulitis, conjunctivitis, and acute respiratory disease. *The authors conclude that further experience will undoubtedly demonstrate the antibiotic to be highly efficacious in all infections caused by susceptible organisms.*

References: 1. Morigi, E.M.E., *et al.*: Antibiotics Annual 1959-1960, Antibiotica, Inc., New York, N.Y. pp. 127-132. 2. Cronk, G.A., *et al.* : *Ibid.*, pp. 133-145. 3. Wright, W.: Reported in Morigi, E.M.E., *et al.* : *Ibid.*, pp. 127-132. 4. Gourevitch, A., *et al.* : *Ibid.*, pp. 111-118.

Average penicillin serum concentrations³ following a single 250-mg. dose

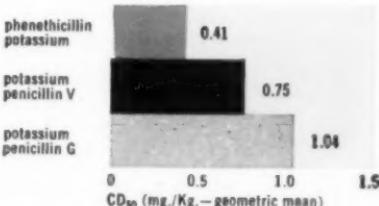
— phenethicillin potassium
— potassum penicillin V



Average penicillin urine concentrations¹ following a single 250-mg. dose

	0-6 Hrs.	6-12 Hrs.	24 Hrs.
phenethicillin potassium	30.9%	0.6%	0%
potassium penicillin V	18.2%	0.2%	0%

Median curative dose⁴
(in animals) of penicillins
against
Staph. aureus



Minimum inhibitory concentrations⁴
of penicillins
using *Staph. aureus*
strains of clinical origin
resistant to penicillin

Staph. aureus	Minimum inhibitory concentrations, Mcg./ml.		
	phenethicillin potassium	potassium penicillin V	potassium penicillin G
52-34	0.8	6.2	12.5
52-75	3.1	25	50
WR-188	1.6	12.5	12.5
BRL J	0.8	1.6	3.1
BRL O	0.8	12.5	25

TABLETS

DARCIL*

Penicillin-152 Potassium
phenethicillin potassium, Wyeth

a new, high-performance penicillin molecule

Wyeth Laboratories Philadelphia 1, Pa.



A Century
of Service
to Medicine

*Trademark

FINANCING YOUR CAR

new cars are sold only through dealers, it may seem sensible to finance your purchase through the man on the spot (who works through what are known as sales-finance companies).

Sales-finance institutions must add finance charges to the face value of the loan. This arrangement is kinder to the borrower than the banks' advance-discount plans. But the sales-finance companies more than make up for the difference by asking higher interest rates.

What You'll Pay

Here's what you might have to pay a typical company—General Motors Acceptance Corp.—for a \$2,600 loan at a 6 per cent nominal annual carrying charge:

¶ Twelve monthly payments of \$229.66, totaling \$2,756; or

¶ Twenty-four monthly payments of \$121.33, totaling \$2,912; or

¶ Thirty-six monthly payments of \$85.22, totaling \$3,068.

Obviously, whether you use bank or dealer-arranged credit, the carrying charge gets heavier the longer the term of the loan.

As the General Motors Acceptance Corp. itself puts it: "When you buy on time, the high cost of so-called easy terms may be easily overlooked . . . The more credit you use, the more credit costs you."

And remember that rates vary both for bank loans and sales-finance arrangements. Interest rates demanded by one bank may well be slightly lower or higher than those asked by another. Dealer plans are even more flexible; their credit arrangements can differ greatly, depending on the locale, the car model, and sometimes what the traffic will bear. So look around a bit before you make up your mind.

Other Possibilities

Of course, there are other ways to raise the money to buy a car. The doctor who can arrange a short-term commercial call loan or a friendly private loan at a true interest rate below 10 per cent will certainly be one up in "interestmanship." And if you want to make a really expensive purchase—say, a \$10,000-

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XYLOCAINE

LOCAL &

TOPICAL

ANESTHETIC

suturing: Xylocaine® HCl Solution applied topically will permit cleaning and suturing of wounds with patient comfort in an emergency or in the office. Fast acting — Safe — Dependable.

bursitis: Xylocaine HCl Solution injected into the painful area will diffuse around the bursae relieving pain promptly — often restoring normal freedom of motion. Prolonged anesthesia often prevents recurring pain.

therapeutic block: Xylocaine HCl Solution interrupts the underlying mechanism of pain, with relief often persisting even after the block has disappeared. It is of value in assisting motion or manipulation; for severe, intractable pain conditions; and in allowing patient comfort for other procedures.

minor surgery: Xylocaine HCl Solution will diffuse over a wide operative field, permitting pain-free removal of warts, cysts, moles, etc., and giving safe, effective, and predictable anesthesia for patient comfort.

Supplied: Multiple dose vials, 20 cc. and 50 cc.; 0.5%, 1% and 2% without and with epinephrine 1:100,000. Ampules, 2 cc.; 2% without and with epinephrine 1:100,000.



ASTRA

*U.S. PAT. NO. 2,641,498

MADE IN U.S.A.

XUM

FINANCING YOUR CAR

\$15,000 Cadillac, Mercedes-Benz, or Rolls Royce—you might even consider open-ending your house mortgage and thus getting the needed cash at a true rate of only 6 per cent or thereabouts. (But you'd better consult a financial adviser before making such a major move.)

To sum up: Unless your money is tied up in highly lucrative investments, consider paying cash for your new car; it's the cheapest way. If you do choose a credit arrangement, you'll do best with a bank loan—and with the smallest possible loan for the shortest possible period. END

No More Insurance Forms!

BY B. G. KROHN, M.D.

I never fill out the health-insurance forms sent me by insurance companies. Thus, I save money and time. Yet my patients always collect their benefits without difficulty.

Do you find the flood of insurance paper work increasingly troublesome? If so, you may want to try my system for handling reports to the companies. It's so simple that I can explain it in a very few words:

I keep my medical records on a form that's similar to the typ-

ical insurance-company form. When I'm asked for a report on a given patient, my aide runs his record through our photocopying machine and mails off the copy.

I've been using this technique for over a year. During this time, my office has processed more than 1,000 insurance claims. I figure that the system has saved me about \$100 a month in secretarial time.

How do the companies react? They've consistently paid prompt

THE AUTHOR is a general practitioner in Bellflower, Calif.

NO MORE INSURANCE FORMS!

benefits to my patients. In only one case have I been asked for further information.

The key to the system lies in the way I keep my medical records. I use standard 8½" x 11" sheets of paper for them, and they're patterned after the standard form of the Health Insurance Council. (You can get sample copies of the basic form from the Council, 488 Madison Ave., New York 22, N.Y.) To see a form a lot like the one I use, glance at the accompanying illustration.

It takes only a few seconds to photocopy one sheet of paper, at a cost of only 5 cents per copy sheet. My aide runs the patient's bill as well as his medical record through the machine. I then sign both copies, and they're mailed to the insurance company along with its blank form and a Mimeographed letter of explanation.

That's all there is to it.

Since insurance companies don't want progress notes on treatment, and since they aren't

entitled to some other types of information, my secretary puts a blank sheet of paper over the detailed-history portion of the form before it's copied. Our records thus remain complete, but the details aren't reproduced for outside eyes.

A Help in Other Ways

One final word: The system I've described has proved to be more than just a time- and money-saver. One of its advantages—an unexpected one—is that my medical records are now more complete and in better shape than they've ever been before. We have to keep them right, or the insurance companies would have cause to complain.

What's more, there's no longer even a twenty-four-hour lag between the time when we get a company's request for information and the time when we respond. So the patient gets his payment fast—and so, therefore, do I.

IT SAVES HIM \$100 A MONTH in secretarial time, and he doesn't have to fill out health-insurance forms. That's what a simple record form somewhat like this one means to Dr. B. G. Krohn of Bellflower, Calif. The insurance company gets a photocopy of everything but the shaded part.

Henry Milford, M.D.

3629 E. Jones St., Detroit 10, Mich.

ATTENDING PHYSICIAN'S STATEMENT

Drake Mrs. Irma S.

Patient's name

1047 Woodward Ave.

Detroit 16, Mich. 24

Address

Age

Hospitalized at St. Mary's Hosp. Address Detroit 14, Mich.

Admitted on 10-21-59 Discharged on 11-6-59

How long was or will
patient be unable to
work? 10-17-59 to 11-24-59

Able to resume work
on 11-24-59

Nature of sickness or injury (not arising out of employment, not due to pregnancy)	Dates of office consultations	Other services: X-ray, lab, physical therapy (incl. dates)	Nature of surgical or obstetrical procedure
<u>Pneumonia, lobar</u>	<u>10-21-59</u> <u>11-13-59</u> <u>11-24-59</u>	<u>Chest X-ray</u> <u>10-21-59</u>	<u>thoracentesis</u> <p>Date(s) performed: Office _____ Hospital _____ In <u>10-22-59</u> Out _____</p>

Henry Milford, M.D.
Henry Milford, M.D.

History, examination, and progress

Injections and Rx

History, examination, and progress

Injections and Rx

END

Lifts depression... a



You see an improvement within a few days. Thanks to your prompt treatment and the smooth action of Deprol, her depression is relieved and her anxiety and tension calmed — often in two or three days. She eats well, sleeps well and soon returns to her normal activities.

...as it calms anxiety!

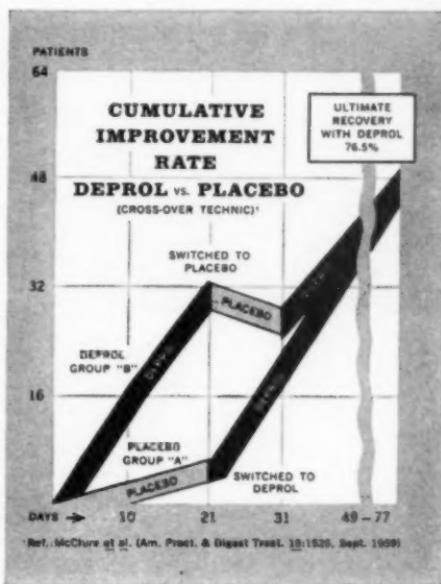
Smooth, balanced action lifts depression as it calms anxiety... rapidly and safely

Balances the mood—no "seesaw" effect of amphetamine-barbiturates and energizers. While amphetamines and energizers may stimulate the patient—they often aggravate anxiety and tension. And although amphetamine-barbiturate combinations may counteract excessive stimulation—they often deepen depression.

In contrast to such "seesaw" effects, Deprol lifts depression as it calms anxiety—both at the same time.

Acts swiftly—the patient often feels better, sleeps better, within two or three days. Unlike the delayed action of most other anti-depressant drugs, which may take two to six weeks to bring results, Deprol relieves the patient quickly—often within two or three days.

Acts safely—no danger of liver damage. Deprol does not produce liver damage, hypotension, psychotic reactions or changes in sexual function—frequently reported with other antidepressant drugs.



Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this may be gradually increased up to 3 tablets q.i.d.

Composition: 1 mg. 2-diethylaminooethyl benzilate hydrochloride (benactyzine HCl) and 400 mg. meprobamate.

Supplied: Bottles of 50 light-pink, scored tablets. Write for literature and samples.

“Deprol”®



WALLACE LABORATORIES / New Brunswick, N. J.

Bendectin at bedtime

no nausea at breakfast



Bendectin stops morning sickness 2-4 hours before it starts

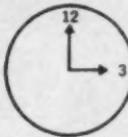
The special coating on Bendectin preserves the effective core for from 4 to 6 hours after ingestion. Medication is released when needed most. Records show just 2 timed-release Bendectin tablets h.s. relieved morning nausea and vomiting in more than 96% of 1139 patients.¹⁻⁴ Because of its unique formula, Bendectin has the actions needed to prevent morning sickness — antispasmodic/antinauseant/plus pyridoxine supplementation.

References: 1. Nulsen, R. O.: Ohio State M. J. 52:605, 1957. 2. Personal communications: 1956-57. 3. Towne, J. E.: Internat. Rev. of Med. 171:584, 1958. 4. Geiger, C.J., et al.: Obst. & Gynec. 6:689, 1959.

BENDECTIN
HERE



MEDICATION RELEASE
BEGINS HERE



MAXIMUM
EFFECT HERE



THE WM. S. MERRELL COMPANY • New York • Cincinnati • St. Thomas, Ontario

TRADEMARK: BENDECTIN®

Certifying Board for G.P.s?

It's Sure to Come

An unofficial American Board of General Practice has already been set up. And although the A.A.G.P. has voted to censure its founders, the door is still open. Here's a first-hand report on the latest moves toward G.P. certification

By John R. Lindsey

Two years ago in Dallas, the American Academy of General Practice voted down proposals to create a certifying board for G.P.s. "How can general practice be a specialty? It's ridiculous!" cried the delegates.

A few weeks ago in Philadelphia, the G.P.s again voted against a board. But this time there were important differences. This year's delegates weren't voting on whether or not to initiate

a board. They were deciding whether or not to endorse a board already set up. And their anger was directed more at the men who set up the board without Academy approval than at the board idea itself.

Their answer was still "No." But at the same time, it seems to me, they took the longest step yet toward G.P. certification. I came away from the Philadel-

Continued on page 216

*Your surgical convalescent
feels better
because he is better
with*

Durabo



Durabolin®

(Nandrolone phenpropionate injection, ORGANON)



1 cc. *for safe potent anabolic stimulation*
+ to maintain positive nitrogen balance
+ to promote rapid wound healing
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CERTIFYING BOARD FOR G.P.s?

phia meeting convinced that a certifying board for G.P.s is bound to come.

I've had to reach my conclusions by reading between the lines, so to speak. Most of the men who are promoting the board idea are reluctant to talk about it openly. But they firmly believe that hospital privileges for newly created M.D.s will eventually be limited to the board-certified. They also believe that demands for board men are increasing from union and other third-party health plans. And though they don't contend that general practice will ever be a specialty, they think that family practice is becoming one—and that if the G.P.s don't preempt the field, it will go to the internists by default.

What about the board that already exists? It hasn't been officially endorsed by either the A.A.G.P. or the A.M.A. But it has been legally incorporated in Maryland as "The American Board of General Practice, Inc."

It's been denounced by some Academy leaders as a renegade board set up in defiance of or-

ganized medicine. But the ten physicians who took out the incorporation papers are not the renegade type.

Who's Behind It

For example, one of the ten is Dr. Lester D. Bibler of Indianapolis, a delegate to the A.M.A. from the A.M.A.'s Section on General Practice. His is a familiar voice in the A.A.G.P. and in the Indiana Academy of General Practice.

Another of the ten men, Dr. Samuel A. Garlan of New York, heads the executive committee of the A.M.A.'s Section on General Practice. A third is the present A.M.A. Section chairman, Dr. Robert L. Crawford of Lancaster, S.C.

The others are all present or former officers in the A.M.A. Section: Dr. Charles E. McArthur of Olympia, Wash., who is president of the new board; Dr. E. I. Baumgartner of Oakland, Md., vice president; Dr. George L. Thorpe of Wichita, Kan., secretary-treasurer; Dr. Charles R. Alvey of Muncie,

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CERTIFYING BOARD FOR G.P.s?

Ind.; Dr. M. B. Casebolt of Kansas City, Mo.; Dr. I. Phillips Frohman of Washington, D.C., and Dr. William J. Shaw of Fayette, Mo.

These men aren't novices in medical politics. They're nationally prominent. What's more, they're not actively seeking office. In short, they can afford to stick their necks out.

Make no mistake about it: They did stick their necks out at Philadelphia. And the delegates reacted by voting to reprimand

them for taking an "ill-advised and unfortunate" action. The assembled G.P.s also agreed to "repudiate the creation of an American Board of General Practice without the knowledge, consent, or approval" of the Academy.

Delegate John C. Ely of Washington State summed up the majority stand as follows: "In view of the ill-advised and irresponsible action of certain individual members of the Academy in incorporating a so-called board of



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CERTIFYING BOARD FOR G.P.s?

general practice, any action by this Congress of Delegates which could be construed by anyone as even tacit approval of this action would work to our eventual detriment. I therefore feel we should disapprove any action tending toward any form of approval of a certifying board at this time."

The founders were slapped hard. At an executive board meeting, one Academy director called the board "a Maryland mule—without pride of ancestry or hope of progeny."

But note this: At the same time that they voted a reprimand, the delegates also left the door to further action wide open. They instructed the Academy's Committee for Liaison with the General Practice Section of the A.M.A. on Certifying Boards to meet with the new board members "in the immediate future."

Their object, although not specifically spelled out, is this: to persuade the founders either to dissolve the board or to find legal means to turn its charter over to the Academy. A preliminary meeting is planned to coincide with the A.M.A.'s annual

meeting in Miami the week of June 13. Whatever happens then, one thing is certain now: the Academy's officers are committed to oppose any kind of certifying board for the present, at least.

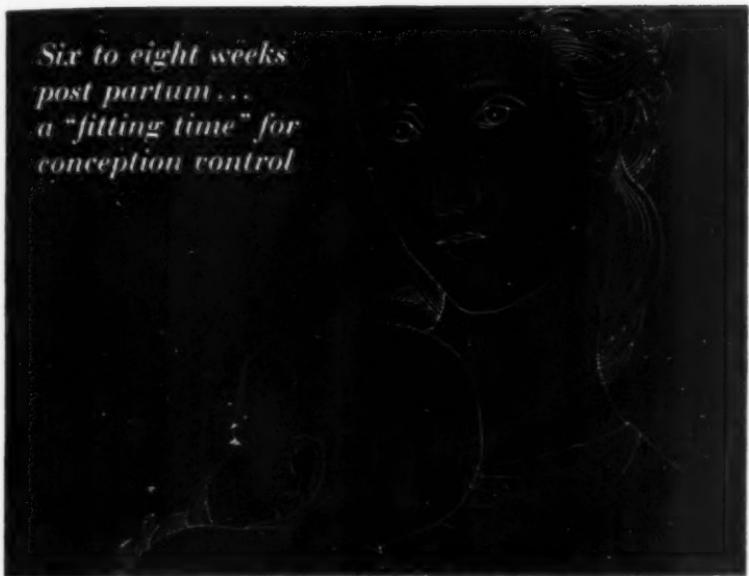
What Was the Motive?

In view of the opposition to a board at this time, why did so many prominent G.P.s decide to put the idea into effect on their own? Were the new board's founders acting spontaneously and independently? Or, as some skeptics have suggested, were they perhaps encouraged to do so by the leaders of the American Academy of General Practice?

I'm convinced there was no collusion. Both the founders and the A.A.G.P. officers have made formal denials. In a special report to the delegates, Dr. Floyd C. Bratt of Rochester, N.Y., the Academy's president-elect, stated flatly: "Notwithstanding the implication in the board's charter that it represents the Academy, we deny responsibility for its parentage. And we recommend that members of the A.A.G.P. de-

Continued on page 226

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Reference: 1. Tietze, C.: Proceedings, Third International Conference Planned Parenthood, 1953.



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your allergic
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will subside
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CERTIFYING BOARD FOR G.P.s?

cline to affiliate with this or any other board which is without official status in organized medicine."

The chairman of the above-named liaison committee, Dr. John Paul Lindsay of Nashville, Tenn., told the delegates that he hadn't been consulted by the board's founders. Moreover, he said, he had no hint of the incorporation move until long after it had been made. Mac F. Cahal, executive director of the A.A.G.P., told me much the same thing. And the founders themselves have assumed full responsibility for their action.

They Give Their Reasons

"We who are about to die salute you," Dr. Lester Bibler said to the delegates. Then he offered this explanation: "The move to incorporate a board wasn't made overnight. We know that the Academy as a whole is not in favor of a board. But many of us have been thinking and talking about a board for a number of years. The thought behind the move to incorporate was this:

"We wanted to safeguard the

title, so that it could not be appropriated by some other organization seeking to set up a board of family practice. We're not competing with the A.A.G.P. No national officer, no state chapter had any knowledge of what we were doing. We apologize for what we have done, but the only motivation for our actions was to protect the future and continued advancement of the A.A.G.P."

No one challenged Dr. Bibler's motivation. And the delegates later approved a statement saying that "there was evidence that the incorporating members were acting in good faith." But a number of delegates questioned whether the "board idea," not the specific title, could be thus safeguarded. And, speaking as the Academy's legal counsel, Mac Cahal suggested that nothing in the incorporation could prevent the internists from setting up a "board of family practice."

What happened, I think, was this: Drs. Bibler, Baumgartner, and the rest elected to take a calculated risk on their own. They

Continued on page 230



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On Nardil "the majority of her anxiety symptoms had disappeared. Later she remarked that she was 100% better.... There has been no return of her former complaints."^{**}

*Hobbs, L. E.: *Virginia Med. Monthly* 86:692, 1959.



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**Sains, A.: *Dis. Nerv. System* 20:537, 1959.

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CERTIFYING BOARD FOR G.P.s?

knew in advance that their board wouldn't be enthusiastically acclaimed by their colleagues. But it seems likely that they also felt sure it was bound to come eventually. So they took the risk of current repudiation on the as-

sumption that other G.P.s would soon *have* to accept the idea.

As the new board's chairman, Dr. Charles McArthur, put it later: "To me the official action of the Academy in shunning a certifying board is a facsimile of the



"... and being, at long last, of sound mind, I leave everything to my psychiatrist."

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BOARD FOR G.P.s?

attitude of the American College of Surgeons in the Thirties. Then they too stuck their thumbs in their vests and puffed out their chests and said in effect, 'We are so important we do not need any certifying board.' Well, you know what's happened since."

Others who feel strongly that such a board is bound to come cite the increasing emphasis on certification in almost all areas where G.P.s are seeking to improve their position. Says Dr. J. Herbert Nagler of Philadelphia, who has acted as spokesman for G.P.s in negotiations with hospitals, Government agencies, and medical schools:

"What we need most in such negotiations is just the word 'board.' It's not enough merely to point to the A.A.G.P.'s requirements for continuing post-graduate study. Those we negotiate with want the assurance of a more familiar yardstick—in short, a board."

Now let's take a look at what the board hopes to accomplish. What are its standards and requirements for diplomates in general practice? What does the future hold for it (or for a sim-

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CERTIFYING BOARD FOR G.P.s?

ilar board that the A.A.G.P. will approve)?

The new board defines general practice as "that area of medical knowledge and therapeutics necessary and usual in the medical and surgical care of the individual patient and of the family unit, with allowance for local customs and practices." And it specifies that any physician "who does not limit himself to one field of medicine or surgery" may be eligible for certification.

Their Requirements

The specific requirements? "Three years of graduate training in programs approved by the Council on Medical Education and Hospitals of the A.M.A. . . plus two years of practice."

There are various possible ways for a candidate to meet the graduate training requirements. Among others, he may substitute two years of preceptorship training for one year of graduate training, after he has completed two years of approved general practice residency. But for men who will be graduated after July 1, 1963, the plan calls for one

year of rotating internship and two years of approved residency.

As for today's practitioners, Academy members of four years' standing may be certified without examination. Others must pass written and oral exams. And the board doesn't intend to permit diplomates to rest on their laurels once they've been certified. Its regulations require recertification every six years.

What does the board hope to accomplish by offering certification? It names two basic goals: (1) recognition of the G.P.-diplomate as a family physician whose credentials of training can be accurately established; and (2) elevation of the standards of training for general family practice to the level already reached by other fields of medicine.

The current board may not realize all its ideals. In view of the A.A.G.P. action against it, it may even be dissolved. But a number of Academy members have told me privately that they're convinced that *some* recognized board of general practice (or of family practice) is inevitably on its way. *More*►

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CERTIFYING BOARD FOR G.P.s?

One straw in the wind: The Advisory Board for Medical Specialties, which must pass on any new certifying board, has been talking with G.P. leaders about better residency programs in general practice. And there have been similar discussions about higher minimum standards for G.P. training, including a minimum of two years' hospital training for future G.P.s.

What's more, the Academy delegates at Philadelphia did adopt new membership rules that require two years of graduate

training following completion of a one-year internship for all future A.A.G.P. candidates. Such a requirement is almost identical with the repudiated board's graduate-training rules.

I don't mean to give the impression that a majority of G.P.s are in favor of a certifying board. They're not. Important voices have been raised against the idea. As Dr. Amos N. Johnson of Garland, N.C., put it to me:

"The desires and ends to be achieved by board certification can and should be accomplished

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1. Gould, W. L.: Impotence. M. Times 84:302 Mar. '56.
2. Personal Communications from 110 Physicians.
3. Milhoan, A. W., Tri-State Med. Jour., Apr. '58.
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For acute attacks: Single dose of 75 cc. for adults; 0.5 cc. per lb. of body weight for children.

For 24 hour control: For adults 45 cc. doses before breakfast, at 3 P.M., and before retiring; after two days, 30 cc. doses. Children, 1st 6 doses 0.3 cc.—then 0.2 cc. (per lb. of body weight) as above.

1. Schluger, J. et al.: Am. J. Med. Sci. 233:296, 1957.

2. Bradwell, E. K.: Acta med. scand. 146:123, 1953.

3. Truitt, E. B. et al.: J. Pharm. Exp. Ther. 100:309, 1950.



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Sherman Laboratories
Detroit 11, Michigan

CERTIFYING BOARD FOR G.P.s?

within the framework of the present American Academy of General Practice.

"I don't think that board certification per se would help attract more young men to general practice. If we're becoming a minority group in *everyday* clothes, it's not going to help us much to put on *Sunday* clothes. Let's say the internists are board-established on the second floor, and the G.P.s on the first floor. Is it going to help the G.P.s as board men to go up to a balcony halfway between the first and second

floors? Let the internists organize their own second-class group and occupy the balcony, if they like."

I'd also like to point out that a number of men whose opinions I respect do not share my impressions of the Philadelphia meeting. For example, Dr. Paul S. Read of Omaha, Neb., a member of the A.A.G.P. Board of Directors, said to me:

"You seem to feel that pressure for a certifying board is increasing and that opposition is weakening. I feel just the oppo-

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1. Lubowe: I. I. Am. Pract. & Digest. Treat. 7:962, 1956.
2. Niedelman, M. L.: Ibid. 8:1753, 1957.
3. Cornbleet, T., et al.: J. Invest. Dermat. 27:61, 1956.

Case report in files of Pfizer Laboratories Medical Department

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XUM

CERTIFYING BOARD FOR G.P.s?

site. Nearly everyone I've talked with since the Philadelphia meeting has expressed the hope that we will improve our standards of educational requirements for membership, but that we will never have a certifying board."

Dr. Read, who says he once believed a board might be inevitable, now takes this position: "Further study has finally convinced me that there is no place for a certifying board. I believe that if the A.A.G.P. increases the post-graduate training requirements for membership and

raises the continuing educational requirements for continued membership, then certification by A.A.G.P. headquarters that we are members will be all the certification that we need."

I'll concede present sentiment is against a board. A recent survey indicates that 58 per cent of the A.A.G.P. members oppose a board and that only 42 per cent are in favor. But in my considered opinion, the pros and cons will be much closer together in another year or two. The pressures for certification are unmistakable

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CERTIFYING BOARD FOR G.P.s?

in big-city hospitals, especially in those with residency programs or university affiliation.

Meanwhile, the internists are making a determined bid for the title of family physicians; some are even talking of a board for family practice. I don't see how the G.P.s can resist such pressures.

The way things stand, there will be no immediate move to set

up an official board of general practice. And the chances are it won't be the Bibler-Baumgartner board, when it comes. But if the pressures increase—as they almost certainly will—the doctors themselves may insist that their Academy do something about it. I'll be surprised if they don't follow the path indicated by the ten adventurous men they recently censured. END

P *osition wanted*

One day during my internship in a maternity hospital, I was assisting at a delivery. The surgeon was a man really interested in teaching. Before starting on the patient, he said to me, "Do a pelvic examination and tell me the presentation and position."

I quickly did so. "It's in L.O.A.," I reported.

Then he examined the patient, who was under spinal anesthesia and half asleep. Turning to me he said, "You were right—but examine her again and you'll see that it's changed to direct O.A."

Before applying the forceps, he enumerated all the different positions. Among others, he mentioned R.O.A., R.O.P., R.O.T., L.O.T., L.O.P., and direct O.P. He took time to explain the significance of each. Then he asked me, "Which would be the best?"

At this point the patient opened her eyes and blurted, "How's about getting it O-U-T!"

—VIRGINIA C. VILLARICA, M.D.

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But they
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*reduces postnasal drainage — lessens pharyngeal irritation
depresses the cough reflex — eases expulsion of mucus*

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(brand of dextromethorphan HBr)	
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Dosage (to be administered every 3 or 4 hours): *Adults*—2 tsp.; *Children 6 to 12*—1 tsp.; *1 to 6-½* tsp.; *under 1-½* tsp. One dose at bedtime is usually sufficient to control the cough cycle initiated by postural drainage of paranasal sinuses.

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2. Lhotka, F. M.: Illinois M. J. 71:259 (Dec.) 1957. 3. Fabricant, N. D.: E.E.N.T. Monthly 37:460 (July) 1958. 4. Farmer, D. F.: Clin. Med. 3:1183 (Sept.) 1958.

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MEDICAL ECONOMICS

Book Feature

In this department, MEDICAL ECONOMICS presents book condensations of a type never available before. Only books of a thought-provoking, nonmedical kind are condensed. But the condensing is directed by editorially experienced physicians. Readers thus get a medical man's view of the best in nonmedical contemporary thought. Among the hard-hitting best sellers that informed people are reading and talking about this month is James MacGregor Burns' "John Kennedy: A Political Profile." A selection from this book starts on the next page. The editors take pleasure in bringing it to you as another of the MEDICAL ECONOMICS Book Features.

Spotlight on Senator Kennedy

*The Catholicism of Candidate John Kennedy has been debated by almost everyone. But what about his other attributes? What sort of President would this man make? You'll find surprising answers in this selection from the best-selling book "John Kennedy: A Political Profile"***

By James MacGregor Burns

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For months before the coming of this critical election year, the acknowledged front runner was one who met none of the accepted tests of Presidential timber. He was not a Governor of a large state or a Cabinet officer or a general. He was not a Protestant. He was not a long-time party leader. He did not personify any great national issue. He was not the champion of any one group or philosophy. He was not in his fifties or sixties, the supposed age for coming into the fullness of one's political powers. He was a Senator hardly past his first term, Catholic, independent Democrat, barely into his forties.

"Unless the opinion polls are totally misleading, millions of Americans are eager to elect this still young, still incompletely tested man to the Presidency,"



SPOTLIGHT ON SENATOR KENNEDY

'As
Honest
As if He
Were
Dead'



James MacGregor Burns is Professor of Political Science at Williams College. Two years ago, he ran for Congress as a Democrat—and lost. Soon afterward, he reports, "Senator Kennedy offered me a responsible position in his office . . . I declined because I felt that . . . I did not know enough about his Presidential qualifications to make the complete commitment that such a job required." Burns still had misgivings when his publishers asked him to write a biography of the Senator. Not unless it could be "as honest a study . . . as if he were a dead statesman," Burns stipulated. Given free access to Senator Kennedy's files, Burns went ahead. He describes the result as "neither an authorized biography nor a campaign biography, but an attempt to supply needed information, a measure of analysis, and a few judgments on one of the best-known and least-understood of American political leaders."

Joseph Alsop has said. "But why?"

How was it that Americans, facing what would be perhaps the most difficult decade in this century, were willing to turn to a man who seemed to stand for so little? a historian asked.

And Columnist Marquis Childs wrote, "At 42, with his unruly shock of hair, Kennedy still looks like a Harvard graduate student out to get his Ph.D. in political science." Yet John Fitzgerald Kennedy was a formidable contender for the most important position in the free world. Why?

Why Kennedy?

Kennedy's political career provides some answers. In his early legislative life, he had won the support of a wide array of political leaders and groups by establishing an image of moderation.

Secondly, he had been, in effect, campaigning for fellow Democrats and for President over a period of four years in every state in the Union (including Alaska and Hawaii) and in Puerto Rico and the Virgin Is-

lands, which also send delegates to Presidential conventions. He had probably appeared before more Democrats than any other Democratic candidate except Stevenson.

Third, his candidacy always carried an extra quality of excitement and newsworthiness because of the controversy over a Catholic for President. On the otherwise rather flat and dreary political terrain, he was the one Democrat, aside from Stevenson, whose political image had been projected into the minds of millions of nonpolitical Americans.

This was not simply to the credit of Kennedy. It was mainly a combination of his youthful, arresting appearance and the capacity of television and picture magazines to project that image into 30,000,000 or more living rooms across the country.

What was this image? When asked by pollsters in the summer of 1959 to describe, in their own words, what kind of person they thought Kennedy was, voters answered in such terms as "energetic . . . intelligent . . . good-

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SPOTLIGHT ON SENATOR KENNEDY

looking . . . strong character . . . good family . . . aggressive . . . dynamic . . . outspoken."

Though some Republicans considered him something of a "smart aleck" and a headline-hunter, most had a favorable image of him; their main grievance seemed to be that he was in the wrong party. Independent voters mentioned his honesty, impartiality, good background. The image of Kennedy expressed in these polls emerged as almost entirely favorable.

How Voters Rate Him

In one poll, toward the end of 1957, voters were asked to evaluate Kennedy on a ten-point scale—from plus five for the most favorable rating to minus five for the lowest. Ten times as many people rated him on the plus side as on the low; most of those who rated him high rated him very high.

There were those who disliked Kennedy, too. For some, his youth and his eager, attractive appearance did not match their image of the country's President. To many of his critics,

he seemed opportunistic, pragmatic, forever shifting with the political breezes. He has, indeed, been described as a "Democratic Nixon," an ambitious, hard-working politician, acting in terms of the immediate situation rather than on general and deeply rooted principles, and hence operating in a moral vacuum.

"Where is the heart in the man—what makes it tick?" asked a close observer on Capitol Hill.

The more one studies the popular image of Kennedy, the more one is struck by its superficial, one-dimensional quality. The mass media have projected the characteristics that go only skin deep. The feeling about Kennedy, if it could be summed up in one phrase, is that he is "a nice guy who would like to be President."

It was with this same kind of phrase thirty years ago that Walter Lippmann dismissed, in words that historians will not let him forget, another Presidential aspirant as an "amiable man with many philanthropic impulses but . . . not the dangerous enemy of anything," as a "pleas-

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SPOTLIGHT ON SENATOR KENNEDY

ant man who, without any important qualifications for the office, would very much like to be President." This was Franklin D. Roosevelt.

What Sort of Man?

Many people think of Kennedy as a sunny, gregarious type who likes nothing more than stumping the country. Or as a glamorous matinee idol who would be a Hollywood star if he were not a Washington politician. Or as a casual, happy-go-lucky kind of person.

Actually, he is a serious, driven man, about as casual as a cash register, who enjoys the organizational, technical part of politics but not the stumping, which he considers simply grinding hard work, and whose resemblance to a matinee idol is purely on the surface.

Kennedy has many qualities of the intellectual. It is not a press agent's pitch, but a solid fact, that he loves to read, to ruminate, to analyze. He is happiest not in social gatherings but sitting in bed, bespectacled, going through a recent biography,

just as he prefers to spend his time with a small group of intelligent people (especially if it includes members of his family) rather than with crowds.

Political life he calls a "treadmill." He never gives the impression of throwing himself into a campaign and loving the noise and confusion as Roosevelt and Truman did, or as Kefauver and Humphrey do now. Campaigning to him is hard but necessary work.

But if Kennedy is an intellectual, it is of a very special type. His mind is more analytical than creative, more curious and penetrating than wide-ranging or philosophically speculative, more skeptical than confident, more catalytic than original or imaginative.

He shuns doctrinaire solutions and dogmatic talk. He is uneasy with slogans—and sometimes with statements of principle. He would prefer to present a dozen assorted reasons for a position than a single, overarching one that to most intellectuals might seem compelling.

He is surprisingly literal-mind-



while she is planning
her family,

she needs your help
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WHENEVER A DIAPHRAGM IS INDICATED

SPOTLIGHT ON SENATOR KENNEDY

ed. Once, when asked at a student convocation what he would do about Little Rock if he were President, he went through a step-by-step description of precisely what legal procedures were open to the Chief Executive. He considers the Eisenhower Administration's favorite phrases tired substitutes for hard thought and action. If there is anything he dislikes more than the liberal stereotypes, it is the conservative ones.

One word describes Kennedy more exactly than any other: self-possession. He has never been seen—even by his mother—in raging anger or uncontrollable tears. He does not lose himself in laughter; the only humor he displays, aside from the contrived jokes of a political speech, is a light, needling, slightly ironic banter, such as one often meets in war or in other times of stress.

He dislikes emotional scenes, at home or at work. His driving ambition to win out in politics seems to rise less from an emotional compulsion—though emotional drive manifests itself in his restless, hard-working, single-

minded will—than from a calm evaluation of what he can do if he puts everything he has into it. He has apparently never lost himself in a passionate, unrestrained love affair; "I'm not the tragic lover type," he said once when pressed about whether he had ever gone through youthful agonies of love.

Where does this quality of detachment, of restraint, of moderation, of self-protection come from? The easy answer is from his glands, or his psyche, just as Hubert Humphrey says with a laugh that it is in *his* glands to throw himself into what he is doing, whether a marathon talk with Khrushchev or a liberal cause.

His Background

But in Kennedy's case, the roots of his dispassionate attitude toward personal and political matters can be traced in part to his background. He grew up in a family that was moving from Boston to New York to Palm Beach and Hyannisport, that was rising from lower-middle-class

Continued on page 258



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two children
but some days
it seems like
twenty-five

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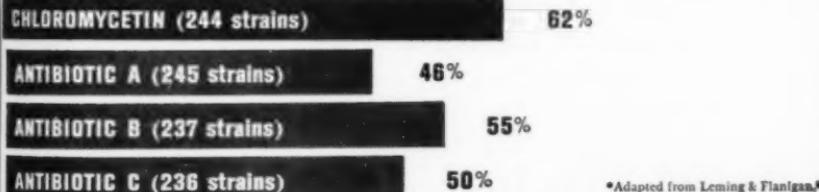
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References: (1) Morton, J. J.: *Yale J. Biol. & Med.*, **21**:397, 1959. (2) Rogers, D. E., & Louria, D. B.: *New England J. Med.*, **261**:86, 1959. (3) Leming, B. H., Jr., & Flanagan, C., Jr., in Welsh, H., & Martí-Blazquez, F.: *Antibiotics Annual 1958-1959*, New York, Medical Encyclopedia, Inc., 1959, p. 414. (4) Edwards, T. S.: *Am. J. Ophth.*, **48**:19, 1959. (5) Olarte, J., & de la Torre, J. A.: *Am. J. Trop. Med.*, **10**:324, 1959. (6) Suter, L. S., & Ulrich, E. W.: *Antibiotics & Chemother.*, **9**:38, 1959. (7) Holloway, W. J., & Scott, E. G.: *Delaware M. J.*, **30**:173, 1958.

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SPOTLIGHT ON SENATOR KENNEDY

environs to the financial and social pinnacle, that swung away from its lace-curtain Irish ties but did not forge new ones with any social or economic or ideological group. Kennedy, while friendly to all groups, has found a place for himself in none.

This fear of making too much of a commitment, of going off the intellectual deep end, is locked in Kennedy's character. On the few occasions when he has acted immoderately, he later regrets it.

For example, long after he told the House of Representatives that the American Legion leadership had not had a single new idea for years, he wondered if he had not overstated his case. The Legion *had* had one or two new ideas, and if he overstated his case very much, Kennedy went on, "People would feel that I was not thoughtful or rational, and I think that's terribly important."

What Sort of Democrat?

This refusal of Kennedy's to make commitments has alienated many liberals and intellec-

tuals who feel that even a reasonable man, and certainly a Presidential candidate, must "stand for something." It has also alienated some professional Democrats.

Where does he fit into the party spectrum? Kennedy is proud of his friendships in the Senate, stretching from Paul Douglas to Barry Goldwater, just as he used to boast of getting along personally with everybody in the House, from Racist John Rankin to Radical Vito Marcantonio.

This is all right for a Congressman, Democrats grant, but what kind of Democrat would he be as President?

"Win ye see two men with white neckties, set in opposite corners while wan mutthers 'thrainer' an' the other hisses 'miscreent,' ye can bet they're two dimmycratic leaders thryin' to reunite th' . . . party," said Finley Peter Dunne's Mr. Doolley. Kennedy is fond of this observation, which is as apt today as a half-century ago.

But to some Democrats, the fights within the party are not just a joking matter; they are the

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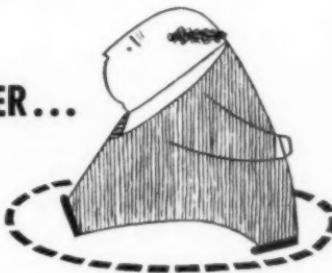
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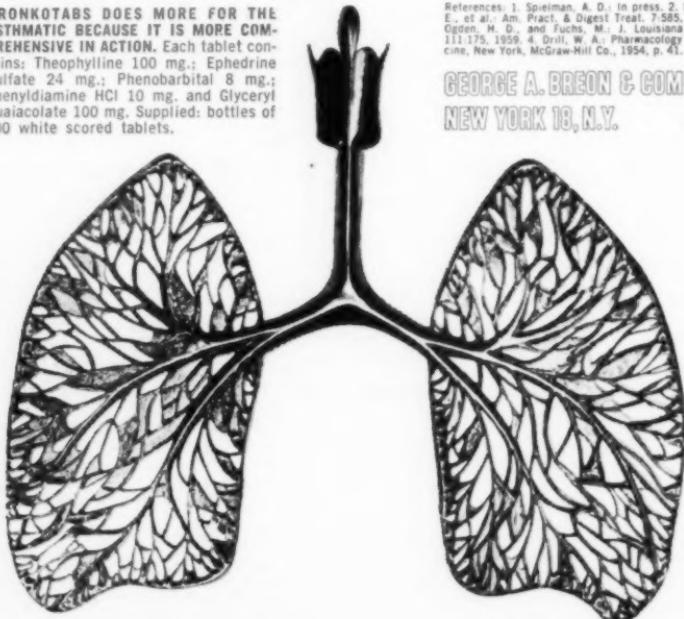
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SPOTLIGHT ON SENATOR KENNEDY

way the party finds out where a man stands. The question is not merely who is *for* him. The question is also who is *against* him.

In Roosevelt's time, Democrats stretched a banner around Madison Square Garden: "We love him for the enemies he's made." What enemies would Kennedy make? Would they be the right ones?

Certainly Kennedy has made unusual efforts to get along with all factions of the party. Always conscious of the convention situation, he knows that the solid opposition of any one of the major Democratic groups—Southerners, union leaders, civil-rights blocs, or farm leaders—would probably be enough to stop him.

But his wish to get along with all party groups is a result of temperamental as well as political considerations. Kennedy doubtless believed that he was paying the ultimate tribute when he described Stevenson once as "beholden to no group or section, belonging neither to a left wing nor a right wing."

Democratic chieftains in Kennedy's camp contend that too

much is made of his appeal to all sections. That appeal, they say, is based on personal friendships, especially with Southern Senators, and on a lag in understanding of Kennedy's Congressional record.

He has not catered to the South or the conservatives in his recent votes, they contend. He has simply stayed a bit to the right of Humphrey without losing his franchise as a Northern Democrat. And they quote one Southern state chairman as calling Kennedy only "the best of a sorry lot."

He's a Moderate

Behind some of the liberal suspicion of Kennedy is not so much distaste for his views as worry over his temperament. They sense that emotionally and temperamentally Kennedy is a moderate, and they are right.

He has often mentioned his admiration for John Buchan's "Pilgrim's Way." And no wonder, for Buchan admired men like Burke and Balfour who would not destroy what many generations had built "merely

SPOTLIGHT ON SENATOR KENNEDY

because some of the plasterwork was shaky."

In Buchan, too, Kennedy found the line by Lord Falkland that he likes so much to quote: "When it is not necessary to change, it is necessary not to change."

He puts it a different way, but with the same meaning, when he quotes Robert Frost: "Don't take down a fence until you know why it was put up."

A Problem to His Party?

The main suspicion of Kennedy among the Democratic pros stems less from doubts over his Democratic creed than from fears over his attitude toward them if elected President. They know of his critical attitude toward decrepit party organizations; of his independence of the party in Massachusetts, at least up to 1956; of his tendency to award patronage plums—the few he has had to give out—to leaders in his own organization rather than to "deserving Democrats." How much would this man upset the status quo in the party?

Mixed in with this worry is concern over Kennedy's age. Party leaders, like other careerists, work their way up the organizational ladder and usually come into their own by their fifties and sixties. When they look at a man a whole generation behind them, they wonder if, intentionally or not, he will shunt them aside and bring into power and recognition a host of his contemporaries.

It is all very well for the Democratic orators to proclaim that America must make its own "leap forward" by changing from the tired Republican Administration of men in their sixties to a vigorous government by younger men. Those leaped over have their misgivings.

Most Democrats care little about such party problems. To them only one question is important: Is Kennedy a liberal in the Wilson-Roosevelt-Truman tradition?

This question often is raised about Kennedy, partly because of his mixed voting record in the past, partly because he dislikes labels and hence cannot be easily

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SPOTLIGHT ON SENATOR KENNEDY

typed. Moreover, he believes that much of the liberalism of the New Deal and the Fair Deal either has become properly entrenched in our way of life, and hence is no longer a disputed political issue, or in a few cases has become outmoded or irrelevant.

Liberalism itself, Kennedy feels, must be rethought and renewed—for example, in farm and business policy. In such a program of liberal renovation, he believes that he could effectively take leadership as an “idealist without illusions,” as his wife likes to call him.

We Need Ideas*

“What we need now in this nation most of all is a constant flow of new ideas,” he has said. “We cannot obtain new ideas until we have a government and a public opinion which respect new ideas and the people who have them . . . Our country has surmounted great crises in the past, not because of our wealth, not because of our rhetoric, not because we had longer cars and whiter iceboxes and bigger television screens than anyone else,

but because our ideas were more compelling and more penetrating and more wise and more enduring.”

Since none of the usual labels seems to fit Kennedy, his friends have gone to some trouble to devise a new one. One has come up with the term “humanism,” meaning, in its nonphilosophical sense, a group of policies emphasizing social welfare and economic security and centering in the family—higher minimum wages, expanded health services, better housing, more protection for the aged, perhaps family benefits like those adopted in Canada.

But a new term is not necessary. Scrutiny of Kennedy’s positions in the last several years shows that he does stand in the center of the Wilson-Roosevelt-Truman tradition, defined as embracing both economic welfare and civil liberties.

Some contended that this was a shift mainly for political expediency as he came nearer to a national campaign. Possibly. But it seemed more likely that his shift went deeper, to a change in



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SPOTLIGHT ON SENATOR KENNEDY

the pressures within him, and not merely those upon him.

By 1958 and 1959, Kennedy was consistently supporting the liberal Democratic party position both on welfare issues and on civil liberties and civil rights. He backed comprehensive housing legislation; introduced a ten-point "bill of rights" for improved living conditions for older people; introduced the first Senate bill to outlaw the bombing of homes, churches, schools, and community centers; continued to advocate statehood for Alaska and Hawaii (considered a civil-rights matter by many Southerners); worked for an anti-lynching bill and an anti-poll-tax bill.

It was significant that the two pieces of legislation he worked on hardest in 1959, aside from the labor reform, were an increase of the Federal minimum wage to \$1.25 and the repeal of the Federal defense education act requiring students to sign loyalty oaths if they wanted loans. Kennedy had come to grasp that the liberal Democratic tradition calls for *both* groceries and liberty.

"I am no Whig!" Kennedy says when asked about his conception of Presidential power. He believes, unlike the Whigs in the early days of the Republic, whose distrust of the people led them to distrust Presidential power, that the Presidency must energize and unify our divided governmental system.

What Sort of President?

Under him, the White House could be expected to generate a steady flow of policies and directives to the sprawling Federal bureaucracy. Kennedy would agree that the American Presidency's supreme role is to provide the "steady focus of leadership." His attitude has changed since his earlier days in the House of Representatives, when he himself seemed to distrust Presidential power.

His would probably be a nonsense type of administration, run by men young, dedicated, tough-minded, hard-working, informed, alert, and passionless. The place would be quiet, taut, efficient—sometimes, perhaps, even dull.

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1. Melville, K. I., and Lu, F. C.: Canadian M.A.J., 65:11, 1951. 2. Bovet, D., and Nitti-Bovet, F.: Arch Internat. de pharmacodyn. et therap., 83:367, 1946. 3. Fuller, H. L., and Kassel, L. E.: Antibiotic Med. & Clin. Therapy, 3:322, 1956.

Thos. Leeming & Co. Inc. New York 17, N.Y.

*Patent applied for

SPOTLIGHT ON SENATOR KENNEDY

There would be little of the automatic delegation of power and responsibility to interdepartmental committees, as in Eisenhower's time; little of the boisterous relaxation of Truman's incumbency, or of the genial, creative disarray of Roosevelt's. The men with dreams but no discernible plan, who could get in to see FDR, would not get past the White House door to see Kennedy. But those with an outline for a program would be welcomed.

Kennedy would look for men—regardless of whether they were labeled Democrats or Republicans, businessmen or professors or labor leaders, liberals or conservatives—who would be most likely to carry out his policies in a forceful, competent manner. He would make his Cabinet a "ministry of all the talents," composed of moderate men "a little left of center."

Administering foreign policy would be men of the caliber, perhaps, of Adlai Stevenson and Chester Bowles; on the domestic side, of the background and temper of Abraham Ribicoff and Al-

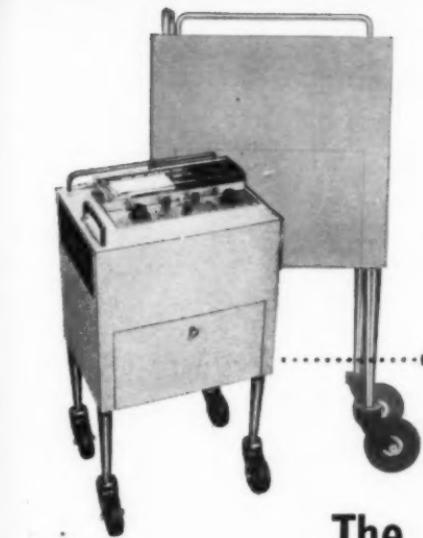
bert Gore. (These names are merely suggestive and do not represent any statements made by Kennedy or his assistants. This is also true of the ensuing discussion of likely policies, except where Senator Kennedy is directly quoted.)

A Kennedy Administration

What would such an administration do? In some respects, its policies would not represent an abrupt break with those of the outgoing Republican Administration.

The sharpest immediate shift would come in Federal social-welfare policies. Depending on the degree of Congressional cooperation, minimum wages would be raised and exemptions narrowed, social security extended, the new labor policy of 1959 revised where in practice it unduly hurt democratic and honest trade unionism, Federal housing and urban renewal subsidies expanded, big Federal aid to school construction passed.

The most striking changes might be in the field of family allowances, with a small Federal



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SPOTLIGHT ON SENATOR KENNEDY

allotment to families for each child; and in medical care, perhaps in the direction of the British health program.

The budget would probably be balanced, at least in a time of full employment, not by cutting Federal spending—an impossibility under the likely policies of a Kennedy administration—but by raising taxes, especially income and corporation taxes, and by plugging tax loopholes.

"If you were elected President, what kind of foreign policies would you pursue? Can you offer any new approaches? Would you try, while maintaining the nation's military and economic security, to set in motion forces that in the long run, at least, might ease East-West hostility and end the cold war? What hope can you hold out of breaking through the current impasse—or at least of releasing forces that might do so over the next decade or two?"

These questions were asked the Senator not long ago during a rare moment of relaxation between legislative activities and campaign tours. The occasion

was a tranquil one; campaigns and cold wars seemed far away. Attired in shorts and sunglasses, Kennedy was lying back on a beach chair in the hot sun on the front porch of his Hyannisport home, a daub of sunburn lotion on his nose. His wife sat by reading; his daughter, Caroline, teetered up and down the porch steps.

A Look at Foreign Policy

"Well, in the first place," he said, "it takes two to make peace. I think it would be misleading to suggest that there are some magic formulas hitherto untried which would ease the relations between the free world and the communistic world, or which would shift the balance of power in our favor. When Khrushchev talks of peaceful coexistence, he makes it quite clear that he means to 'bury' us by means other than war.

"If our military power remains paramount—and I would include the traditional weapons as well as the nuclear weapons, for brushfire wars remain our great military problem—then it might be

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SPOTLIGHT ON SENATOR KENNEDY

possible to encourage the Russians and the Chinese to say a farewell to arms. We can then expect the competition would shift to nonmilitary spheres. It will then be a struggle between the two systems, then a test as to which system travels better—which system of political, economic, and social organization can more effectively transform the lives of the people in the newly emerging countries.

"There are many things we must do to win this struggle. We must recognize that free Africa will hold a balance of power in the General Assembly and in the world and will control some 25 per cent of the votes in the General Assembly. These are new countries with staggering problems which need assistance from the West both economically and educationally . . .

"A new Democratic administration, as the legatee of Franklin Roosevelt, would have a great opportunity to rebuild close relations with Latin America, if it supports a common market, the stabilization of raw materials, etc., demonstrating in other ways

recognition of the real interdependence of North and South America . . .

Kennedy on India

"We have a great opportunity also in India, which contains within its borders nearly 40 per cent of all the people in the underdeveloped world and which has had the advantage of highly skilled economic planning.

"If India's third five-year plan fails, then India and Asia fail. It's for that reason that Senator John Cooper and I have been interested for the last two years in sending a high-level Western economic mission to India and surrounding countries in order to let both Europe and the United States—acting together—participate in reaching an economic breakthrough there. If China succeeds and India fails, the economic-development balance of power will shift against us.

"We should also take advantage of the present potential thaw to develop more intimate relations with Poland and those countries behind the Iron Curtain. It is because I believe that



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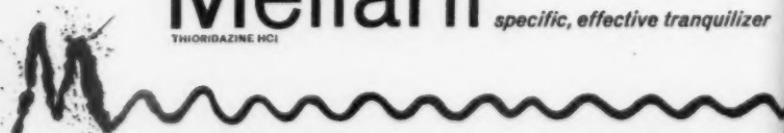


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SPOTLIGHT ON SENATOR KENNEDY

this represents the Achilles' heel of the Soviet empire that I have been attempting (with George Aiken) to change the Battle Act to permit a freer flow of trade in many areas between these countries and ours . . .

"We must rethink all of our policies in the Middle East—the Baghdad Pact, the Eisenhower Doctrine, the refusal to go ahead with the Aswan Dam—all mistakes. They were all based on concepts of the Middle East that were no longer valid.

His Views on Red China

"We should make decisions now about vacating Quemoy and Matsu, which are indefensible and which provide a needless irritant that could drag us into a struggle with Red China, a struggle in which we would be isolated by world opinion.

"If we are going to have difficulty with the Chinese, and we well may, then we should make sure that it involves basic principles of national independence and survival so that we may expect the goodwill of our allies and the neutrals.

"While the Red Chinese do not now indicate their willingness to relax their external and internal pressures in order to meet the standards which should precede our recognition and their admission to the United Nations, nevertheless we should indicate our willingness to talk with them when they desire to do so, and to set forth conditions of recognition which will seem responsible ones to a watching world.

"In the final analysis, our foreign policy, our relations with other countries, will be most affected by what we do here in the United States. If we have a strong and well-distributed military strength, if our productivity is moving ahead, if we are devoting a reasonable share of our resources to assist the underdeveloped areas to make their economic breakthroughs, if we are first in scientific achievements—in making fresh water out of salt water at a competitive rate, for example—if our educational system is being strengthened, and there is equality of oppor-

Continued on page 276



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SPOTLIGHT ON SENATOR KENNEDY

tunity for all Americans—*then* we will have demonstrated that freedom rather than communism represents the wave of the future . . .”

“But is all this enough? Obviously, as President you would try to be effective and resourceful in strengthening the unity of the Free World and maintaining a durable power balance against the Communists. But in the long run, balances of power have a tendency to topple, do they not?”

Kennedy answered: “In the long run, there are many changes in power ratios. But I believe if we can hold out for the long run, there will be sufficient evolutionary changes in the communistic system in Russia as well as in China to give us some hope of success.

“The magic power on our side is the desire of every person to be free, of every nation to be independent . . . That is the weapon and elementary principle for the destruction of the Communist empire in Eastern Europe. It is because I believe our system is more in keeping with the fundamentals of human nature that

I believe we are ultimately going to be successful, provided we have sufficient self-discipline and perseverance to maintain our own strength through a long testing period.”

“Since at least Polk’s time, not one of the great Presidential leaders, Wilson possibly excepted, gave clear evidence before entering the White House of a capacity to shape a program, arouse public opinion behind it, control Congress, and dominate the bureaucracy. Today the Presidential office holds vast legal power and moral influence, but how that power and influence are marshaled and focused depends on the occupant and the nature of the times. What is your estimate of the job of the President during the next decade?”

He Looks at the Future

“The 1960s will be a terribly difficult time. I think Eisenhower is going to get home relatively free. At the end of his term, there will probably be full employment, a level price index; the drop in food prices may equal

Continued on page 280

why Willoughby was perplexed



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UROLOGY RESIDENT: *He did, but the Chief straightened him out. He admitted that combinations are often misused. But Mr. Blaine, with a bladder infection, was in pain, and furthermore it will take a couple of days before we get the lab report. Mixed infections are common. And since the tetracycline and sulfa in AZOTREX are effective against the gram-positive and gram-negative bugs usually found, we could start therapy right away.*

SURGICAL RESIDENT: *Makes good sense, so far.*

UROLOGY RESIDENT: *Also, the good blood levels with tetracycline phosphate complex help eradicate the deeper foci of infection and sulfamethizole gives high urinary sulfa concentrations without crystalluria.*

SURGICAL RESIDENT: *Say, how come you remember so much? Are you reviewing pharmacology for your "boards"?*

UROLOGY RESIDENT: *I jotted down some notes. Anyway, the Chief likes the way the azo dye in AZOTREX rapidly relieves pain. Also, it is easier for a sick person to swallow a single capsule instead of three.*

SURGICAL RESIDENT: *A sound approach. How about lunch?*

UROLOGY RESIDENT: *Good idea. Shall we go to the staff lounge?*

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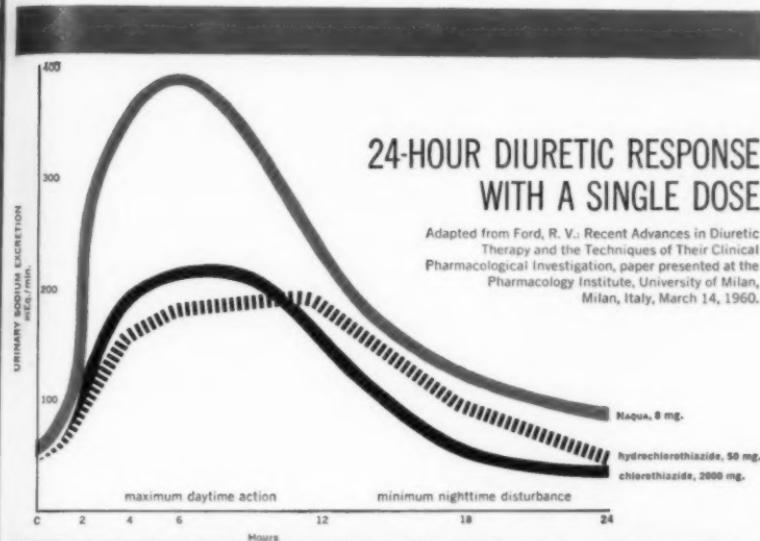
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(1) Reports to Division of Clinical Research, Schering Corporation. (2) Ford, R. V.: Am. J. Cardiol. 5:407, 1960.

SPOTLIGHT ON SENATOR KENNEDY

any increase in industrial costs. There will probably be a deal on Berlin for eighteen months or so, and the now-independent countries will have survived.

"But it will be like Calvin Coolidge giving way to Herbert Hoover. All the pigeons coming home to roost will be circling over the head of the man coming in. In 1961 or '62, all the problems—changes in weapons structure, changes in NATO, desperate inflation and economic problems in the southern half of the globe—will be coming to a head. The job of the next President will be the hardest since Roosevelt, and I think Roosevelt had the hardest of all except Lincoln and perhaps Washington

"The real dilemma we face is whether a free society in which each of us follows our own self-interest can compete over a long period of time with a totalitarian society in which both the carrot and the stick are used to force all human and material resources into the service of the state.

"There are many short-term advantages which a totalitarian possesses in that kind of com-

petition. The struggle between Sparta and Athens furnishes a classic case.

He Defines the Job

"The responsibility of the President, therefore, is especially great. He must serve as a catalyst, an energizer, the defender of the public good and the public interest against all the narrow private interests which operate in our society. Only the President can do this, and only a President who recognizes the true nature of this hard challenge can fulfill this historic function."

"In the Senate, you have been something of a traditionalist. You have opposed bypassing the Eastland committee; you have favored the seniority system for choosing committee chairmen, or at least seen no hopeful alternative; you have defended the American system of divided power seemingly down to the last check and balance. How does this position fit in with your concept of Presidential leadership?"

"Even in the Senate today," Kennedy said, "I'm not, in a sense, a traditionalist. For ex-



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SPOTLIGHT ON SENATOR KENNEDY

ample, I supported strongly the Fulbright development loan program putting the development fund on a long-term basis through direct borrowing from the Treasury rather than annual appropriations, thus bypassing the Appropriations Committee.

"I'm willing to follow the traditional procedure if we're going to get action, even if it means a delay of a week or two. But I won't follow the procedures if it means diluting or destroying action.

'A Revolutionary Time'

"It's going to be a hell of a revolutionary time—the increase of population here and abroad, changes in the underdeveloped world, changes in weapon strategy, and all the rest. The best the President can do is to track down the best talent he can get . . . and then try, by his political management, by his mobilization of public opinion, by his hard work almost day by day in Congress and the nation, to bring along that more conservative and localized body.

"How far would I go? I be-

lieve that our system of checks and balances, our whole constitutional system, can only operate under a strong President.

"The Constitution is a very wise document. It permits the President to assume just about as much power as he is capable of handling. If he fails, it is his fault, not the system's. I believe that the President should use whatever power is necessary to do the job unless it is expressly forbidden by the Constitution.

"Congress is quite obviously not equipped to make basic policy, to conduct foreign relations, to speak for the national interest in the way that the President can and must . . . In the next two or three decades, there will be greater demands upon the President than ever before—and the powers are there, if the man will use them."

"To what extent would Congressional problems boil down to the conflict between North and South in the Democratic party?"

"Of course there are conflicts within the Democratic party. It is inevitable that there will be when you have a national party

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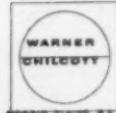


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SPOTLIGHT ON SENATOR KENNEDY

which takes in varying regions which have been the scene of great historical struggles. But I believe that the Democratic party on the whole is progressive and will support a vigorous and progressive President. I think having had Congressional experience, which Eisenhower never had, could mean a good deal toward success in the job . . .

"In the final analysis, this phase of the work comes down to how good a politician the President is or wants to be. You remember Eisenhower, when early in his first term a questioner asked him how he liked the game of politics, replied with a frown that his questioner was using a 'derogatory' phrase. 'Being President,' he said, 'is a very fascinating experience—but the word "politics"—I have no great liking for that.'

"I do have a great liking for the word 'politics.'"

A Place of Moral Leadership?

Kennedy as President would mobilize traditional tools of Presidential power and use them with force, astuteness, and tenacity.

He would show a flair for personal influence and manipulation, perhaps some of the flair Roosevelt had. He would drive hard bargains, forming alliances with Republicans when necessary, but he would be willing to compromise, too, when he lacked the votes.

But would all this be enough?

The Presidency "is pre-eminently a place of moral leadership," Franklin D. Roosevelt once said in a now-famous quotation. "All our great Presidents were leaders of thought at times when certain historic ideas in the life of the nation had to be clarified."

It is precisely in this respect that Kennedy's critics, especially in the liberal wing, have trouble imagining him in the White House. What great idea does Kennedy personify? In what way is he a leader of thought? How could he supply moral leadership at a time when new paths before the nation need discovering?

To these questions, Kennedy's friends offer no certain answer. They do point out that Kennedy



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SPOTLIGHT ON SENATOR KENNEDY

is not unique in this respect—that few other candidates in recent years, except for Taft and perhaps Stevenson, and few recent Presidents, displayed strong leadership in behalf of a solid program.

They argue, too, that something besides high-toned moral leadership may be needed for the 1960s—for example, adroitness and tenacity in getting through Congress measures to meet the accumulating needs of the nation.

Is He the Man for It?

Obviously, much depends on the demands of the times. If the 1960s call simply for consolidation, continuation, and expansion of the New Deal-Fair Deal policies, Kennedy's political skill and liberal convictions would be enough for the Presidential job.

But what if the 1960s are a time of radical change, of unprecedented new crises? What if problems arise for whose solution guideposts do not exist?

Such times would call for two types of leadership, and each would demand something of

Kennedy that he might have difficulty supplying.

One type is creative leadership. Instead of responding to political pressures and gusts of public opinion, the President seeks positively to change the shape of public opinion. He has many tools for this—speeches, press conferences, whistle-stop trips, fireside chats, and the like.

But his most powerful tool is not persuasion but action. By boldly taking a position, without regard to Gallup polls, newspaper editorials, or Congressional timidity, the Chief Executive can alter the whole constellation of political forces—at least until the next election.

During one of his Presidential campaign tours, Kennedy spoke to the United Negro College Convocation in Indianapolis. His remarks were intelligent, liberal, eloquent, and unimpassioned. Afterward a long line formed the length of the big hall to shake Kennedy's hand. But hardly anyone in the line talked about the speech; they seemed interested only in meeting the attractive

Continued on page 290



asthmatic...but symptom-free All day long, on the job or off, Tedral protects most asthmatic patients from bronchospasm, mucous congestion and the fear and embarrassment of recurrent seizures. One Tedral tablet, taken at the first sign of attack, blocks the acute phase. For prophylaxis, most patients can be effectively, safely and economically maintained in symptom-free security on just 1 or 2 Tedral tablets q.i.d.

TEDRAL®

the dependable antiasthmatic



TE 815 -

**first of a new class of therapeutic agents
for superior, safer, faster control
of common emotional disturbances**

to free the patient
from anxiety and tension,
whether presenting symptomatology
or associated with
organic or functional disorders.

to free the therapy
from the drawbacks of previous agents.

to free the physician
from the frustrations of prolonged,
inconclusive treatment and to render the
patient more amenable to therapy.

Uses of Librium: *in the office patient*, troubled by anxiety and tension, and by the irritability, fatigue and nervous insomnia associated with tension states • *in the office patient*, where you suspect anxiety and tension as contributing or causative factors of organic or functional disorders • *in more severely disturbed patients*, including cases of agitated and reactive depression, fears, phobias, obsessions and compulsions.

Published reports on Librium: 1. G. A. Constant, *Dis. Nerv. System*, 21: (Suppl.), 37, 1960. 2. T. H. Harris, *ibid.*, p. 3. 3. L. O. Randall, *ibid.*, p. 7. 4. H. A. Bowes, *ibid.*, p. 20. 5. J. M. Tobin, I. F. Bird and D. E. Boyle, *ibid.*, p. 11. 6. J. Kinross-Wright, I. M. Cohen and J. A. Knight, *ibid.*, p. 23. 7. H. H. Farb, *ibid.*, p. 27. 8. C. Breitner, *ibid.*, p. 31. 9. I. M. Cohen, *ibid.*, p. 35. 10. L. J. Thomas, *ibid.*, p. 40. 11. R. C. V. Robinson, *ibid.*, p. 43. 12. S. C. Kaim and I. N. Rosenstein, *ibid.*, p. 46. 13. H. E. Ticktin and J. D. Schultz, *ibid.*, p. 49. 14. J. N. Sussex, *ibid.*, p. 53. 15. I. N. Rosenstein, *ibid.*, p. 57. 16. I. N. Rosenstein and C. Silverblatt, to be published.

Supplied: 10-mg, green-and-black capsules. Bottles of 50 and 500.
For complete information regarding dosage and precautions, please
consult product literature.

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Division of Hoffmann-La Roche Inc • Nutley 10 • N. J.

LIBRIUM™ Hydrochloride — 7-chloro-2-methylamino-5-phenyl-3H-1,4-benzodiazepine 4-oxide hydrochloride

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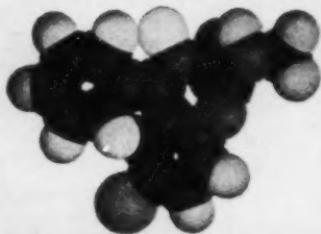
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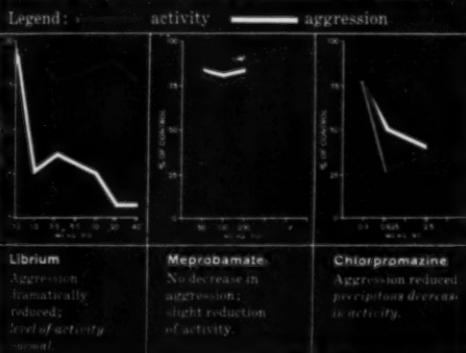
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NEW LIBRIUM



EFFECT ON ACTIVITY AND AGGRESSION IN MONKEYS*



In a class by itself—chemically

Not a manipulated molecule, the structure of Librium resembles no other drug.

In a class by itself—pharmacologically

Librium shows an unprecedented "taming" action in animals. It is the first compound exerting specific anti-aggressive activity without a generalized depressant effect on locomotor activity and reflex patterns.

In a class by itself—clinically

The spectrum of Librium "envelops and extends well beyond that of meprobamate and into certain indications for which the phenothiazines are prescribed."¹ Quantitatively and qualitatively superior to "tranquilizers" and "equanimity-producing drugs," Librium is distinguished by an unusually rapid onset of action and a high degree of safety.

SPOTLIGHT ON SENATOR KENNEDY

young man who had delivered it. He had satisfied them intellectually and attracted them visually—but he had not aroused them spiritually.

Watching Kennedy campaign in Wisconsin in October, 1959, Cabell Phillips of The New York Times noted the same quality. Kennedy radiated a gentle, honest warmth when among small groups, and people were instinctively at ease with him. "He tightens up noticeably, however, on a platform, facing larger audiences. He is more the advocate than the orator, and lines out his speech in a flat, hurried monotone . . . He rarely reaches for a laugh or builds a climax or plucks at the heartstrings—nor, inevitably, has he often to wait for the applause to die down."

An Intellectual Approach

Kennedy is a rationalist and an intellectual. He wants political campaigns to be conducted like debates—"courteous but candid, friendly but frank, incisive without becoming inflammatory . . ." He has denounced the "horrible weapons of modern in-

ternecine warfare, the barbed thrust, the acid pen, and, most sinister of all, the rhetorical blast."

But it was in part with rhetorical blasts that Wilson and Roosevelt moved their party and their country—and the world. Could Kennedy supply creative leadership of this sort?

In his studies of why Britain slept, he placed the chief blame on the failings of the people as a whole and little on the leaders who might at least have tried to arouse them.

In his "Profiles in Courage," the heroes seemed simply to face the choice of giving in to public opinion or of defying it and becoming martyrs. But is there not another alternative—especially for Presidents: consciously shaping public attitudes by positive leadership?

The other type of leadership that the 1960s may demand is charismatic leadership—the capacity to inspire, to lift the hearts, to exalt, to make people lose themselves in a cause they do not fully comprehend.

Continued on page 294



IT'S ALL IN THE FAMILY

Many pediatricians, orthopedic men and general physicians have found in Stride Rite children's shoes outstandingly skilled construction and workmanship — and therefore recommend them. Stride Rite makes a fine girls line of shoes. And Stride Rite also makes a boys line of equal quality and merit. So when you recommend Stride Rites to parents, you may do so as unhesitatingly for boys as for girls.

If you are not familiar with Stride Rites, won't you write us for information about the shoes that understand *all* children . . . and for the facts about Stride Rite's Straight Last and Extra-Support shoes.

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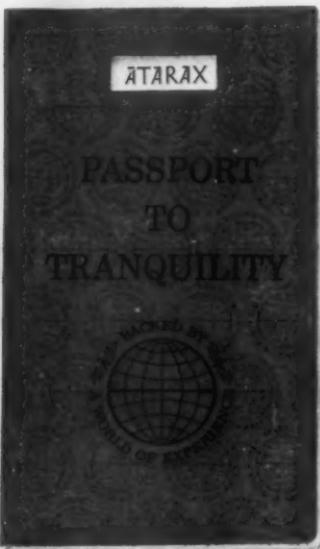
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THE REALMS OF THERAPY BEST ATTAINED WITH



ATARAX quite consistently brings release from anxiety and tension without objectionable side effects. In addition, ATARAX has proved pre-eminent in certain therapeutic areas (briefly reviewed to the right)—areas that, to many doctors, are now clearly staked out as "ATARAX territory." Have you explored them all?

WORLD-WIDE RECORD OF EFFECTIVENESS—over 200 laboratory and clinical papers from 14 countries

WIDEST LATITUDE OF SAFETY AND FLEXIBILITY—no serious adverse clinical reaction ever documented

CHEMICALLY DISTINCT AMONG TRANQUILIZERS—not a phenothiazine or a meprobamate

ADDED FRONTIERS OF USEFULNESS—antihistaminic; mildly antiarrhythmic; does not stimulate gastric secretion

Special Advantages	Supportive Clinical Observation	... and for additional evidence
 unusually safe; palatable syrup, 10 mg. tablet	"...Atarax appeared to reduce anxiety and restlessness, improve sleep patterns and make the child more amenable to the development of new patterns of behavior..." Freedman, A. M.: Pediat. Clin. North America 5:573 (Aug.) 1958.	Bayart, J.: Acta paediat. belg. 10:164, 1956. Ayd, F. J., Jr.: California Med. 87:75 (Aug.) 1957. Nathan, L. A., and Andelman, M. B.: Illinois M. J. 112:171 (Oct.) 1957.
 well tolerated by debilitated patients	"...seems to be the agent of choice in patients suffering from removal disorientation, confusion, conversion hysteria and other psychoneurotic conditions occurring in old age." Smigel, J. O., et al.: J. Am. Geriatrics Soc. 7:61 (Jan.) 1959.	Settel, E.: Am. Pract. & Digest Treat. 8:1584 (Oct.) 1957. Negri, F.: Minerva med. 48:607 (Feb. 21) 1957. Shalowitz, M.: Geriatrics 11: 312 (July) 1956.
 useful adjunctive therapy for asthma and dermatosis; particularly effective in urticaria	"All [asthmatic] patients reported greater calmness and were able to rest and sleep better...and led a more normal life....In chronic and acute urticaria, however, hydroxyzine was effective as the sole medication." Santos, I. M., and Unger, L.: Presented at 14th Annual Congress, American College of Allergists, Atlantic City, New Jersey, April 23-25, 1958.	Eisenberg, B. C.: J.A.M.A. 169:14 (Jan. 3) 1959. Coirault, R., et al.: Presse méd. 64:2239 (Dec. 26) 1956. Robinson, H. M., Jr., et al.: South. M. J. 50:1282 (Oct.) 1957.
 does not impair mental acuity	"...especially well-suited for ambulatory neurotics who must work, drive a car, or operate machinery." Ayd, F. J., Jr.: New York J. Med. 57:1742 (May 15) 1957.	Garber, R. C., Jr.: J. Florida M. A. 45:549 (Nov.) 1958. Menger, H. C.: New York J. Med. 58: 1684 (May 15) 1958. Farah, L.: Internat. Rec. Med. 169:379 (June) 1956.

ATARAX®

brand of hydroxyzine-HCl

APPLIED: Tablets, 10 mg., 25 mg., 100 mg.; bottles of 100. Syrup 10 mg. per tsp., pint bottles. Parenteral Solution, 25 mg./cc. in 10 cc. multiple-dose vials; 50 mg./cc. in 2 cc. ampules.



New York 17, N. Y.
Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being

SPOTLIGHT ON SENATOR KENNEDY

Such leadership calls for magical qualities of heart and spirit, of joy and earnestness, indeed of rhetoric and passion, that are bequeathed to few men. It calls for faith in leadership on the part of the people, and the capacity of the leader to invoke and deserve that faith.

Charismatic leadership can be dangerous, too, for it may demand too much trust, blind faith, and dependence on a father image. But at its best—and assuming always the safeguards of free speech and fair elections—that leadership may be essential to guide a democracy through perilous times.

Kennedy Like Roosevelt?

It is illuminating to compare Kennedy's potential with that of Roosevelt. In some respects the two resemble each other.

Like Roosevelt, Kennedy forged his own liberalism out of day-to-day experience rather than abstract dogmas; was caught between different classes and traditions and lingered between different worlds; became a pragmatist, a realist, a hardheaded

political tactician willing to compromise—sometimes to the despair of his supporters—in order to gain some progress.

Like Roosevelt, he can stand up under tremendous pressure; but a seemingly trivial thing—in Kennedy's case usually the antics of certain Massachusetts politicians—can lead to sharp irritation and some blowing off of steam.

Kennedy, like Roosevelt, is a moderate in his behavior as well as in ideas. He has a gentleman's distaste for lack of self-discipline, and self-restraint, for displays of emotion, for personal brawls and scenes. The bright charm is only skin deep; underneath there is a core of steel—metallic, sometimes cold, sometimes unbending, unusually durable.

With Some Differences

But there are differences, too—and these relate to Roosevelt's special qualities of leadership.

Kennedy lacks Roosevelt's humor and joyousness, his superb acting ability, his magnetism with crowds, his power of oral expression. He lacks also

allergic nose?

Dimetane Works!

with side effects as few as placebo

—New England J. Med. 261:478, 1959 (Schiller, I. W. and Lowell, F. C.)

Dimetane works with an effectiveness of 91% in respiratory allergies

—NEW YORK J. MED. 59:3060, 1959
(Fuchs, A. M. and Maurer, M. L.).

In allergic and pruritic dermatoses the effectiveness rate of Dimetane is 94.6% —ANTIBIOTIC MED. & CLIN. THERAPY 6:275, 1959 (Lubow, I. I.).

The A. M. A. Council on Drugs characterizes Dimetane as demonstrating "...a high order of antihistaminic effectiveness and a low incidence of side effects."

—J. A. M. A. 170:194, 1959.

for your next allergic patient **B** DIME^TTANE Exten-tabs® (12 mg.), Tablets (4 mg.), Elixir (2 mg./5 cc.), new DIME^TTANE-TEN Injectable (10 mg./cc.) or new DIME^TTANE-100 Injectable (100 mg./cc.).



A. H. ROBINS CO., INC., RICHMOND 20, VIRGINIA / ETHICAL PHARMACEUTICALS OF MERIT SINCE 1878

SPOTLIGHT ON SENATOR KENNEDY

Roosevelt's blarney and exaggerations and deviousness.

Clinton Rossiter has said that if Roosevelt was "as busy as Rabbit and as bouncy as Tigger, he was too often, I fear, as big a bluffer as Owl." But in a time of danger and evil, Roosevelt was able to use his less attractive qualities—as well as his superb imagination and daring—against democracy's foes.

Kennedy In Action

Would Kennedy show similar imagination and daring under crisis conditions?

A final answer to the question must take into account the role of the Presidency itself. The office has shown an almost magical power, as in the case of Truman, to elevate men, to bring out the best in them, to convert able politicians into great political leaders.

Throughout his life, Kennedy has had the capacity to move into an office, exhaust its possibilities, and move beyond it. He is too young, curious, and flexible not to continue to grow. His life seems to show a steady

growth into commitment from a position of detachment.

If the Presidency has an impact on its occupants, however, the times have an impact on the Presidency. It may be that the 1960s will be less demanding than the decade over which Roosevelt, or even Eisenhower, ruled. But Kennedy believes that they will be far more demanding and dangerous.

"For now the age of consolidation is over, and once again the age of change and challenge has come upon us," he has said. "The next year, the next decade, in all likelihood the next generation, will require more bravery and wisdom on our part than any period in our history. We will be face to face, every day, in every part of our lives and times, with the real issue of our age—the issue of survival."

To that battle for survival, Kennedy could bring bravery and wisdom. Whether he would bring passion and power would depend on his making a commitment not only of mind, but of heart, that until now he has never been required to make. END

**B-D HYPAK
SAFE**
BECAUSE IT'S GLASS

10
15
20
1 IN.
25
30 ml
5 ml
B-D HYPAK
MADE IN U.S.A.
DISCARDIT

SAFE FOR TODAY'S MEDICATIONS...AND TOMORROW'S

NO CAUTION LABEL NEEDED—Use it with any injectable medication...there is no danger of solvent action on the barrel. **SAFE**—B-D Control guarantees sterility, nontoxicity, non-pyrogenicity. **ECONOMICAL**—Disposability eliminates time-consuming, pre-use preparation. **PRECISE**—Exclusive tip design reduces medication loss.



BECTON, DICKINSON AND COMPANY • RUTHERFORD, NEW JERSEY

B-D HYPAK AND DISCARDIT ARE TRADEMARKS OF BECTON, DICKINSON AND COMPANY, INC. TESAR



when the diagnosis is clear...

in superficial fungous infections of skin, hair and nails due to
Microsporum, *Trichophyton* and *Epidermophyton* organisms



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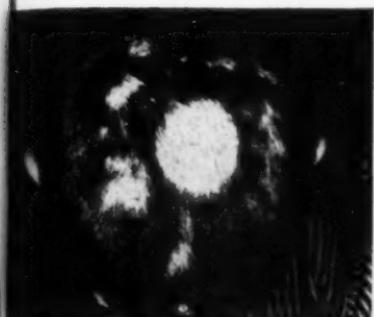
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the ringworm is cleared

and the patient is freed from the *embarrassment* of epilation and skullcaps, the *nuisance* of topical medications and the *potential hazard* of x-ray treatments.



Before FULVICIN—tinea capitis in a 7-year-old boy. Infecting organism: *Microsporum audouini*. Duration of disease: 1 year.



After FULVICIN—tinea capitis 2 months after the conclusion of 6 weeks of oral treatment.

PHOTOS COURTESY OF W. MURRAY KEEGAN, M.D., CALUMET CITY, ILL.



Before FULVICIN—tinea pedis of the soles caused by *Trichophyton rubrum*.



After FULVICIN—remarkable improvement in tinea pedis lesions after 3 months of oral treatment.

PHOTOS COURTESY OF HARRY L. NECHLER, M.D., NEWARKPORT, ORE.

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when the diagnosis is clear...

in superficial fungous infections of skin, hair and nails due to
Microsporum, *Trichophyton* and *Epidermophyton* organisms

first oral ringworm control

fulvicin™
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Before FULVICIN—tinea capitis in a 7-year-old boy. Infecting organism: *Microsporum audouini*. Duration of disease: 1 year.



After FULVICIN—tinea capitis 2 months after the conclusion of 6 weeks of oral treatment.

PHOTOS COURTESY OF M. MURRAY KIEKHAF, M.D., CALUMET CITY, ILL.



Before FULVICIN—tinea pedis of the soles caused by *Trichophyton rubrum*.

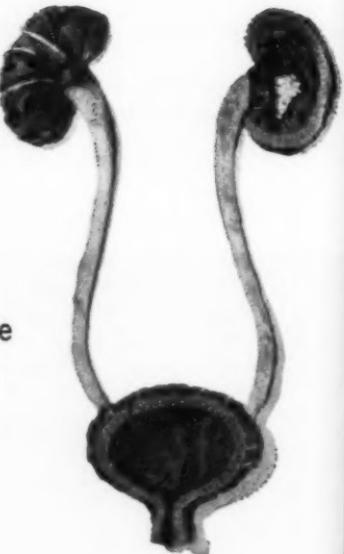


After FULVICIN—remarkable improvement in tinea pedis lesions after 3 months of oral treatment.

PHOTO COURTESY OF HARRY L. WECHSLER, M.D., NEW YORK, N.Y.

B-410

Just a "simple"
case of cystitis
may be the
precursor of
pyelonephritis¹—
or may actually be
the first evidence
of a pre-existing
pyelonephritic
process.²



WHEN TREATING CYSTITIS—SPECIFY

FURADANTIN®

brand of nitrofurantoin

to ensure rapid control of infection
throughout the urogenital system

FIRST

Rapid bactericidal action against a wide range of gram-positive and gram-negative bacteria including organisms such as staphylococci, Proteus and certain strains of Pseudomonas, resistant to other agents ■ actively excreted by the tubule cells in addition to glomerular filtration ■ negligible development of bacterial resistance after 8 years of extensive clinical use ■ excellent tolerance—nontoxic to kidneys, liver and blood-forming organs ■ safe for long-term administration

AVERAGE FURADANTIN ADULT DOSAGE: 100 mg. q.i.d. with meals and with food or milk on retiring. Supplied: Tablets, 50 and 100 mg.; Oral Suspension, 25 mg. per 5 cc. tsp.

REFERENCES: 1. Campbell, M. F.: Principles of Urology. Philadelphia, W. B. Saunders Co., 1957. 2. Colby, F. H.: Essential Urology. Baltimore, The Williams & Wilkins Co., 1953.

NITROFURANS—a unique class of antimicrobials—neither antibiotics nor sulfonamides

EATON LABORATORIES, NORWICH, NEW YORK

We Formed a Part-Time Partnership

Continued from page 73

calendars some weeks ahead of time.

Though I've said that our arrangement leaves us free to practice by our solo standards, it's important to add a qualification. We're careful not to dramatize any differences between us. For that reason, we've adopted the same fee schedule. Two years ago, we decided to raise our fees. Because we did it simultaneously, we avoided difficulties.

We've also done our best to eliminate another potential source of friction. It could be fatal to an arrangement like ours if people suddenly took it into their heads to switch from one of us to the other. So we're scrupulously careful not to accept each other's patients on a permanent basis. Most people seem to understand and respect our attitude. As for the very few who don't—well, we let them switch if they insist.

Our arrangement isn't perfect, to be sure. If we were full-scale partners, for instance, each of us could get away for an extended vacation more easily than we now can. One of us can take over the other's work for a week-end, or perhaps a week. But that's about all we can handle. So when I want a long vacation, I have to obtain a locum tenens.

Still, whenever our part-time set-up falls short of perfection, I think back a few years. In those days I felt overwhelmed by the steadily increasing demands on my time and energy. What I needed was free time, in short spells, so that I could relax.

Today, I *can* relax after work. My disposition is better. My family life has revived. And I have more patients than ever. The only thing that hasn't changed is the nature of my practice. It's still my own.

That's why I recommend my plan to any solo practitioner who has the problem I had. I've learned that it's possible to have the satisfactions of the medical individualist, plus the partnership man's leisure time. END

'Cheap' Insurance Can Rob You and Your Patients

Continued from page 79

he falsifies—writes 'No' to questions like 'Have you ever had heart disease?' when the applicant has told him 'Yes.' When the policyholder tries to collect, the claim is then rejected on the ground that he lied on the application.

"We've had cases like that quite often. But when you have thousands of agents from 500 different companies writing insurance, it's hard to weed out the dishonest ones. We do our best, but you have to get absolute proof on an agent before you can cancel his license. And these fellows are here today and gone tomorrow. People should buy insurance only from people they know to be honest and qualified salesmen."

As for advertisements, deceptive wording is a hard thing for most ordinary readers to see through. For instance, an ad may

well promise payments of "up to \$1,000 for hospital bills." The reader naturally infers that the company stands ready to pay all hospital expenses below that figure.

But that's a false inference, as every doctor knows. The "up to \$1,000" phrase could mean, for example, that a given policy provides \$10 a day for 100 days at the most. Thus, if the insured were hospitalized for fifteen days at a total cost of \$300, his insurance would cover only \$150 of it.

Similarly, "up to \$300 for surgical fees" might mean merely that the policy's fee schedule contains some highly improbable cranial procedure tagged at \$300, with benefits of \$25 to \$50 for everyday operations. And other come-on phrases, like "full benefits for life" or "no medical examination required," may have comparable built-in hedges.

Most such ads also include a coupon that will fetch "full details" or "a sample policy to examine at leisure." The full details are sometimes scarcely fuller than the ad itself. And how

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NEW AND EXCLUSIVE FOR SUSTAINED TRANQUILIZATION

MILTOWN® (*meprobamate*) now available
in 400 mg. continuous release capsules as

Meprospan®-400

JUST ONE CAPSULE
LASTS ALL DAY

HIGHER POTENCY
FOR GREATER CONVENIENCE

- relieves both mental and muscular tension without causing depression
- does not impair mental efficiency, motor control, or normal behavior

Usual dosage: One capsule at breakfast,
one capsule with evening meal

Available: Meprospan-400, each blue capsule contains

400 mg. Miltown (meprobamate)

Meprospan-200, each yellow capsule contains

200 mg. Miltown (meprobamate)

Both potencies in bottles of 30.

 WALLACE LABORATORIES, New Brunswick, N.J.

EWS-8428

'CHEAP' HEALTH INSURANCE

much of his leisure will the average citizen devote to inspecting a closely printed sample policy?

So, by means of free-wheeling agents and romantic ads, grossly limited policies may be sold throughout the nation. Does this mean you should advise your patients to steer clear of all companies that are licensed only in certain states? Or should you suggest that they avoid all mail-order health insurance?

The answer to both questions is no. As Dr. Jameson observes, "The big majority of health-insurance companies everywhere, including those in Arkansas, are reputable. The trouble comes from a few concerns that apparently hold their moral obligations lightly."

Adds the New York State Insurance Department, in a warning on unauthorized insurers: "A blanket condemnation of insurers which solicit and obtain insurance largely through . . . the mails . . . would be neither just nor accurate."

What if a patient should ask your advice on buying a policy

from a certain company? Obviously, few practitioners can give an expert opinion on so complex a matter. But at least you can warn him about misleading ads. You can advise him to deal only with agents he knows something about. You might point out to him that if the company's a member of the Health Insurance Association of America, it operates under a stern code of ethics. And, beyond this, if the company isn't licensed in your state, you might suggest he write to the state insurance department to inquire as to the company's reputation. Thus, you can help him steer clear of dubious health insurance that could so easily mean trouble for him—and you.

It Can Lose You Friends

In so doing, you'll be doing your bit for a larger cause. As Dr. Jameson points out, "Besides the harm these piratical companies have done to their policyholders, they've greatly harmed the good relations between the public and the insurance profession, the hospitals, and the medical profession." END

Schering

*allergic rhinitis? in any case, for
allergic symptoms, the most widely used
antihistamine is CHLOR-TRIMETON.*

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the complaint: "nervous indigestion"

the diagnosis: any of several nonspecific and functional gastrointestinal disorders requiring relief of symptoms by sedative-antispasmodic action with concomitant digestive enzyme therapy.

the prescription: a new formulation incorporated in an enteric-coated tablet, providing the multiple actions of widely accepted Donnatal® and Entozyme.®

the dosage: two tablets three times a day, or as indicated.

Each DONNAZYME tablet contains

—In the gastric-soluble outer layer: Hyoscymine sulfate, 0.0518 mg.; Atropine sulfate, 0.0097 mg.; Hyoscine hydrobromide, 0.0033 mg.; Phenobarbital ($\frac{1}{8}$ gr.), 8.1 mg.; and Pepsin, N. F., 150 mg.

—In the enteric-coated core: Pancreatin, N. F., 300 mg., and Bile salts, 150 mg.

DONNAZYME®

A. H. ROBINS COMPANY, INC., RICHMOND 20, VA.

Can a Doctor Afford to Be Controversial?

Continued from page 83

gardless of the merits of segregation vs. integration. And we argued that our opponents, the die-hard segregationists, were only hurting the South by their policy of "massive resistance."

We argued our case publicly and privately, using all the spare time and means at our disposal. It was a tough fight. For one thing, we had to fight the city government, which didn't see things our way at all. We weren't even allowed to hire a school auditorium for our meetings!

We also had to bedevil the Governor, whose legal powers in our local situation were considerable. We called on him personally. Later, we sent delegations from our growing membership to follow up.

In addition, we had to get through to the state legislature. When the lawmakers held emergency sessions to deal with the

school crisis, our people were there. They spoke up—in the name of our organization—at every public hearing.

Finally, we took our case into the courts. I never went to court personally, but I did give financial aid to several court actions.

For this phase of our campaign, we devised tactics different from what the South had seen before. Previously, the plaintiffs in segregation cases had been Negroes. But our plaintiffs were white. They were suing not for integration, but for the reopening of schools that had been ordered integrated. We reasoned that many more white children than Negro children were being hurt by the shutdown of the up-to-now white schools. We also figured that a victory by a white plaintiff would carry more weight with the die-hards of our city and state.

If's Worst Aspect

All this activity cost me more than just time and money. From the very beginning, my name constantly made the newspapers. Like everybody else on my side

CAN A DOCTOR AFFORD CONTROVERSY?

of the fence, I was soon being reviled, joked about, snubbed. Many of us got anonymous phone calls, night and day, of the "I hope your daughter marries one" variety.

In the end, we won our battle. Both state and Federal courts handed down favorable decisions. The Governor modified his earlier stand. Our local schools reopened, accepting something over a dozen Negro students on opening day.

Since there's no guarantee that we've won for keeps, we're staying on the alert. We want the schools to remain open—and to remain good schools. We hope to get more and more citizens to stand up and be counted with us.

The Balance Sheet

But enough time has gone by so that I can now tally up the costs, economic and otherwise, of these activities. Items:

¶ Lost: no friends. Strayed: many acquaintances. Found: many new friends among those who worked to save the schools. Best of all, I now know that my friends are *really* friends.

¶ Lost: few patients. Gained: equally few. Many patients agreed with me. Of those who disagreed, the vast majority respected my right to hold and voice my opinions. I haven't missed the bitter few who left.

Effect on Referrals

¶ Lost: a few important physician-sources of referral. Some colleagues who are strongly segregationist and highly vocal have talked against me within the profession. This could have hurt, and it may yet. A typical rumor, completely false and ridiculous, was that my daughter was dating a Negro. On the other hand, these unfair and vicious tactics have apparently made some other doctors sympathetic toward me. I've begun to get referrals from physicians who'd never sent me patients before.

On balance, then, my practice seems neither to have suffered nor gained much. Each month's gross follows the last in completely predictable fashion. I had a conviction, took a chance, and got away with it.

My experience was similar to



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CAN A DOCTOR AFFORD CONTROVERSY?

that of Dr. Edward Haddock, the remarkable G.P. who has been mayor of Richmond, Va., and is now a Virginia state Senator. Dr. Haddock, a huge, jovial man of deep religious conviction, was the first legislator to voice an objection to Virginia's "massive resistance" measures. When he ran for re-election in 1959, people went from door to door telling wild tales about him. Yet he led his ticket by 2,500 votes.

Says Dr. Haddock: "Politics

has never hurt my practice one iota, and I know my patients come to me because they believe in me."

A different and much sadder tale might be told by another physician, Dr. Louise Wensel. A G.P. in a small Virginia town, Dr. Wensel ran as an independent in 1958 against Mr. Massive Resistance himself, Senator Harry F. Byrd. Retribution against her was thorough and brutal.

More►



"And now, how about running it backwards, just for the hell of it?"



BAKER'S MODIFIED MILK CONTAINS FULL REQUIREMENTS OF ESSENTIAL VITAMINS



OPTIMUM NUTRITION:
Providing all the normal dietary requirements plus a reserve for stress situations.

1. National Research Council Recommended Dietary Allowances, NAS-NRC Pub. 589 (1958).

Baker's Modified Milk contains all essential vitamins in quantities sufficient to supply Recommended Daily Allowances¹ to infants whose daily formula intake is as low as 26 ounces. This results in: **ACCURACY** —adequate vitamin intake is certain; **OVERDOSEAGE** is virtually eliminated. **GREATERTOLERANCE**—digestive upsets are minimized, because **VITAMIN-VITAMIN** vehicle antagonisms are eliminated. **SIMPLICITY**—since vitamins are already in the formula, there is no extra work or bother. **ECONOMY**—mothers don't have to buy supplementary vitamins; there is no additional cost.

The Baker Laboratories, Inc., Cleveland 3, Ohio

CAN A DOCTOR AFFORD CONTROVERSY?

She didn't suffer economically. Since her action was accepted or at least tolerated by most of her community, her practice actually tended to increase. But her partner was pressured into leaving her, a flimsy lawsuit was brought against her, and her husband lost his job as a state psychologist. Even so, she held on gamely—until persistent threats against her children's safety convinced her that, for the sake of her family, she must move to another state.

What's the moral? Simply that the doctor who's faced with a controversial issue must weigh his convictions and responsibilities against the possibility of economic—or other—loss. He cannot logically hide behind his profession any more than any other citizen can.

If he's financially solvent and if he practices in a place large enough for the offended patients who leave to be replaced by others, he need have little fear. On the other hand, if a doctor is vulnerable to those who might do him serious damage, he should think long before acting. Espe-

cially if he practices in a small town where feelings are magnified by isolation, he may find the cost very great.

Too great? Not necessarily. Each doctor's situation and outlook are unique. For example, consider Dr. Louise Wensel once more. She sparked the first big wave of public opposition to massive resistance in her state. It gathered strength and force until it culminated in a 20-19 vote in the Virginia Senate that is credited with having saved public education in Virginia.

Was It Worth It?

Without a doctor's courageous start, that movement might have failed. Does Dr. Wensel think it was worth the cost? Here's what she wrote me not long ago: "My answer to your question, 'Can a doctor afford to be controversial?', would still be yes."

If I had lost the gamble I took, if I had been forced to move away, would I too have thought it was worth the cost? I can only say I'm grateful I didn't have to pay that price. END

When the diet
is in
doubt

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Excellent nutrition is basic to good health. Yet many busy adults, even those who can afford to eat substantially, "... subsist on diets that are inadequate in vitamin content to meet their requirements. To protect them against the development of vitamin deficiencies, it is necessary to resort to the use of supplemental vitamin therapy, in addition to diet instruction and nutrition education."¹

Multicebrin provides comprehensive vitamin supplementation. Its formula is carefully standardized to meet the most rigid specifications for potency and stability. Protect your patients whose diets are in doubt by prescribing one Gelseal® Multicebrin a day.

1. Geohart, R. S.: Vitamin Therapy Today, M. Clin. North America, 40:1473, 1956.

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LILLY VITAMINS . . . "THE PHYSICIAN'S LINE"

OUTDOOR

Best Performers Among the Mutual Funds

Continued from page 90

concerned. And it fell more than 4 per cent during the early 1960 shake-out. The picture for Group Food was similarly gloomy.

Balanced Funds

The companies in this group are designed for the investor who's more interested in preserving his capital—and getting some income now—than in capital gains. Accordingly, such funds as Boston, Putnam, and Wellington concentrate on more conservative investments than do the common-stock funds.

Their shares constitute a complete investment program in themselves. Portfolios contain a large proportion of so-called defensive securities—bonds and preferred stocks—that are likely to hold up well in a recession. In fact, when the outlook turns gloomy, they put large proportions of their assets into cash or

Government bonds. Significantly, many balanced funds doubled the percentage of their liquid assets between the beginning and the end of 1959.

Last year, as usual, the balanced funds sacrificed capital gains for income. In most cases, increases in share value were less than half as great as for Standard & Poor's 500-stock average. But for many of them the early-1960 loss was also only about half as much.

So it seems clear that the balanced funds are meeting the test of preserving capital. Their performance in delivering income is about what you'd expect, too. The average 1959 dividend paid by a cross-section of typical balanced funds was 3.2 per cent (the same as the average for the Standard & Poor stocks).

Bond Funds

These companies appeal to investors who want a fixed, steady income, even if there's little chance for capital gain. They put none of their money into common stocks, though some invest in preferred stocks. *More*►

When panic strikes your preoperative patient

VISTARIL, as part of a preoperative regimen, can safely relax your patients by allaying fear and apprehension. They are able to sleep soundly at night, and usually remain calm but alert during the day. Postoperatively, VISTARIL quiets anxiety and controls emesis.

supply: *Capsules*—25, 50, and 100 mg. *Oral Suspension*—25 mg. per teaspoonful (5 cc.). *Parenteral Solution* (as the HCl)—10 cc. vials and 2 cc. Steraject® Cartridges, 25 mg. per cc.; 2 cc. ampules, 50 mg. per cc.

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Pfizer Science for the world's well-being™



BEST PERFORMERS AMONG MUTUAL FUNDS

As a result, though none of our cross-section enjoyed capital gains in 1959, their interest payments averaged a relatively high 5 per cent. That's better than double the return from the common-stock funds.

And, interestingly enough, some of the funds in this group actually showed *increases* in net asset value during early 1960. For example, National Securities Bond Series rose 2 per cent; the

Keystone B-1 Fund rose 2.4 per cent. Such gains may seem small. But they're in sharp contrast to the shrinkage shown by every other group. (Assets with fixed face values always appreciate when other investments weaken. Chief reason: An assured yield seems attractive at such times.)

Canadian Funds

The Canadian mutual funds concentrate most of their invest-

How 4 Bond and Preferred-Stock Funds Performed

In 1959 and early 1960*

	Change in Value Per Share		
	12/31/58 to 12/31/59	12/31/59 to 2/15/60	1959 Dividend Income
Investors Selective Fund	-1.3%	-1.0%	4.9%
Keystone B-1	-4.3	+2.4	4.1
National Sec. Bond Series	-5.3	+2.0	5.2
National Sec. Pref. Stock Series	-2.0	-0.3	5.6
<i>Average</i>	-3.2%	+0.8%	5.0%
<i>Standard & Poor's 500-Stock Index</i>	+8.8%	-7.9%	3.2%

*The calculation of per-share value assumes that capital-gain distributions are reinvested. The 1959 dividends from income are based on net asset value as of December 31, 1959.



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MUTUAL FUNDS

ments north of the border, in the hope of cashing in on Canada's mineral riches and fast growth rate.

All but one of them offer special tax advantages, too. With that single exception—Canadian Fund—they are nonresident-owned Canadian corporations that reinvest all their earnings. Thus, you don't have to pay U.S. income taxes on dividends. And when you eventually sell your shares, all your profits from these holdings are taxed at the low capital-gains rate.

Last year wasn't an outstanding one for the Canadian stock market: The Toronto 20-stock average there rose only 3 per cent. Understandably, many of the Canadian funds didn't do much better.

But there were a few exceptions. Canadian International Growth Fund jumped up 21 per cent, for instance; and Keystone of Canada gained 11.7 per cent. Such atypical performances resulted from the fact that these funds are also heavily loaded with recently flourishing European issues.

Continued on page 322

Whatever the indication,*
whatever degree of sedation desired,
a form of Nembutal will meet the need



*OBSTETRICS—Eclampsia, Nausea and Vomiting, Amnesia.



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NEMBUTAL® (PENTOBARBITAL, ABBOTT)

(Nothing Faster, Shorter-Acting, Safer in Barbiturate Therapy)

MEDICAL ECONOMICS · MAY 9, 1960 · 319

**90% of anxious, agitated
and apathetic office patients
calmed without drowsiness
and with normal drive restored..**

on one or two 0.25 mg. tablets b.i.d.:

This is the pattern of performance for

PERMITIL®

Fluphenazine dihydrochloride



In Anxiety and Anxiety-induced Depression

"In contrast to other phenothiazines, it [PERMITIL] mitigates apathy, indifference, inertia and anxiety-induced fatigue. Thus, instead of impeding effective performance of daily tasks, it increases efficiency by facilitating psychic relaxation. Consequently, acceptance of this drug, especially by office patients, has been excellent."¹

- In 608 patients with anxiety and anxiety-induced fatigue or depression, PERMITIL, administered in small daily doses of 0.5 mg. to 1 mg., produced significant improvement in 90%.²
- PERMITIL is virtually free from side effects at recommended dosage levels.
- Patients become calm without being drowsy and normal drive is restored.
- Onset of action is rapid; effect is prolonged.
- PERMITIL does not potentiate barbiturates or non-barbiturate sedatives and can be used with impunity with such agents.

How to prescribe PERMITIL: The lowest dose of PERMITIL that will produce the desired clinical effect should be used. The recommended dose for most adults is one 0.25 mg. tablet twice a day (taken morning and afternoon). Increase to two 0.25 mg. tablets twice a day if required. Total daily dosage in excess of 1 mg. should be employed only in patients with relatively severe symptoms which are uncontrolled at lower dosage. In such patients, the total daily dose may be increased to a maximum of 2 mg., given in divided amounts. Complete information concerning the use of PERMITIL is available on request.

SUPPLIED: Tablets, 0.25 mg., bottles of 50 and 500.

REFERENCES: 1. Ayd, F. J., Jr.: Current Therapeutic Research 1:41 (Oct.) 1959. 2. Recent compilation of case reports received by the Medical Department, White Laboratories, Inc.

PERMITIL



White Laboratories, Inc., Kenilworth, New Jersey

BEST PERFORMERS AMONG MUTUAL FUNDS

Could you have done better over the last year or so by investing on your own rather than through a mutual fund? Of course, there can't be an exact answer to this question. Depending on your skill, your luck, or the quality of your investment advice, you might have done much better or much worse.

Some doctors who did their

own picking made a killing last year. Those who chose the right auto or electronics company—to name two of the most rewarding fields—easily doubled their money. But the men who guessed wrong—sugar or shipbuilding, for example—took a drubbing.

Out of 1,051 common stocks listed on the New York Stock Exchange, 623 showed a price

How 8 Canadian Funds Performed

*In 1959 and early 1960**

	Change in Value Per Share		
	12/31/58	12/31/59	12/31/59 to 2/15/60
	to	to	
Canada General Fund	+ 0.3%	- 6.4%	
Canadian Fund	- 1.8	- 6.1	
Canadian International Growth Fund	+21.0	- 6.2	
Investors Group Canadian	- 0.9	- 6.8	
Keystone Fund of Canada	+11.7	- 6.9	
New York Capital Fund of Canada	+ 7.2	- 4.7	
Scudder Fund of Canada	+ 4.2	- 6.6	
United Funds Canada	+ 1.3	- 5.4	
<i>Average</i>	+ 5.4%	- 6.1%	
<i>Toronto Stock Average</i>	+ 3.0%	- 5.6%	

*Per-share value is calculated on the basis of reinvestment of all capital gains and dividends. With the exception of the Canadian Fund, none of the above companies pays cash dividends.



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Obedrin and the 60-10-70 Basic Plan provide the three essentials of weight reduction:

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2

A balanced
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3

Supportive
medication

Obedrin curbs unhealthy food craving, enabling the patient to establish correct eating habits . . . first, to lose excess pounds and then, more important, to maintain optimum weight.

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Pentobarbital, 20 mg., to guard against excitation



Thiamine Mononitrate, 0.5 mg., **Riboflavin**, 1 mg., and **Nicotinic Acid (Niacin)**, 5 mg., to supplement the diet



Ascorbic Acid, 100 mg., to help mobilize tissue fluids

* Einfold, Henry W.: Treatment of Obesity. The Role of the Doctor, Drug and Diet in Weight Loss, Am. Pract. and Dig. of Treat., 17:75 (Oct., 1954).

Sherman, Robert J.: Weight Reduction, Med. Times, 82:107 (Feb., 1954).

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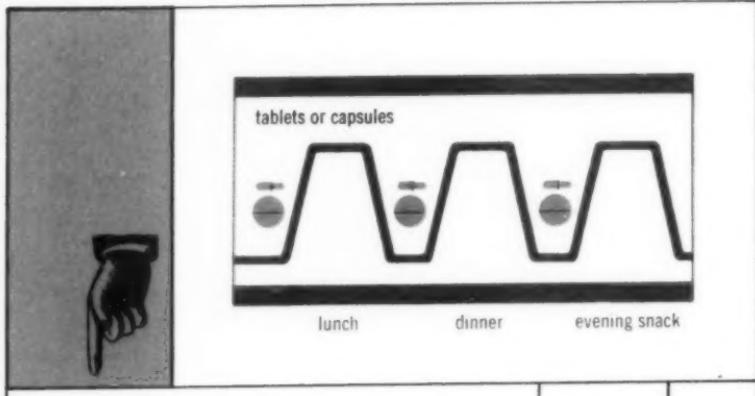
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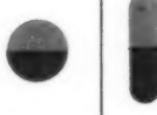
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MUTUAL FUNDS

increase in 1959, 413 showed a loss, and fifteen remained unchanged. Nearly one out of five stocks rose by more than 30 per cent; that's better than *any* mutual fund did. But about one out of five Exchange stocks dropped by more than 10 per cent—which was far worse than any major fund did.

Throughout the year, few of the funds made really impressive gains. But they all managed to avoid painful losses. Thus, they lived up to the expectations of most of their investors (people who are content to share in the *broad* gains of the stock market). In any highly diversified investment, such a result is almost inevitable. You're buying a cross-sectional slice of the entire market. This limits your profits; but, on the bright side, it also limits your losses.

On the whole, the mutual-fund shareholder probably came out a bit ahead of the average independent investor during the months from January, 1959, to March, 1960. Maybe he has nothing to cheer about. But he has little cause for complaint, either.

END

With Your Help, THE MENTALLY ILL CAN COME BACK



Give them the chance
you'd want for yourself:
a job, a home, a place
in the community.



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Prescribe Dr. Scholl's Arch Supports in cases requiring mechanical relief from Foot Arch Trouble of any kind. The patient will be properly fitted and the Supports adjusted as the condition of the foot warrants, at no extra cost. This nation-wide service is available at many leading Shoe and Dept. Stores and at Dr. Scholl's Foot Comfort® Shops in principal cities.

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How to Handle the 'Chiseler' in Your Practice

Continued from page 94

cooperate in "stealing" money from liability-insurance companies, the Veterans Administration, etc. Even the doctor himself may be considered fair game, as evidenced by this statement from a Louisiana internist:

"One of my patients had a \$50-deductible medical insurance policy carried by his employer. I treated him for a severe illness. My fees amounted to \$400. The patient recovered \$350 from the insurance company—and ignored my bills. But when he filed his income tax return, he used them as proof of his claim to a \$400 medical expense deduction."

"How can you cope with such blatant cheating?" asks a North Carolina G.P. "Our greatest problem is with the insurance companies that pay the patient instead of the doctor," he explains. "The patient brings forms to be completed, saying, 'I'll pay

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g.i. intolerance and systemic toxicity.^{1,2} Permits
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ALL SAFE TO HAVE AROUND THE HOME

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Also available: **CHÉL-IRON PLUS Tablets**—chelated iron plus B₁₂,
folic acid, other B vitamins, and C.

1. Franklin, M., et al.: Chelate Iron Therapy. *J.A.M.A.* 166:1685, 1958.
2. A.M.A. Council on Drugs: New and Nonofficial Drugs. *J.A.M.A.* 171:891, 1959.
3. A.M.A. Committee on Toxicology: Accidental Iron Poisoning in Children.
J.A.M.A. 170:676, 1959.

KINNEY & COMPANY, INC. Columbus, Indiana



* U. S. Pat. D. 2,578,011

HOW TO HANDLE THE 'CHISELER'

you when the company pays me.' If you don't complete the forms, you won't get paid; if you do, you may not get paid either. What's the answer?"

Several doctors say they've found one. Here it is, as set forth by a California EENT man:

"I had so many patients run out on my bill after collecting direct from their insurance company that I finally got my back up. I now ask the patient to sign a printed form directing the company to pay me. When an occasional individual refuses to sign,

I simply let him go. I figure all I'm losing is a deadbeat."

Overwhelmingly, the doctors report that most chiselers fall into two main groups:

1. Patients who try to get the doctor to fake the onset or duration of an illness, to falsify his fee for treatment, or to lie about the number of visits he made or the extent of disability.

2. Patients who drag out symptoms to continue collecting from insurance companies, Government agencies, or employers.

Continued on page 330

INITIATIVE
REMAINS
INTACT

NO
PERSONALITY
DISTORTION

ANXIETY-TENSION STATES RESPOND TO

BUTISOL has a known, predictable action—small daily dosage "will produce satisfactory daytime sedation...with minimal occurrence of untoward reactions."

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DOSAGE: 15 to 30 mg. three or four times daily.

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Proc. 77, 372 (March 1961)

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Are your obese patients cheating on their diets?



Nervous nibbling, hunger pangs and monotonous diets destroy the patient's will to reduce.

THE DIETENE PLAN

provides two high-protein Dietene milk-shakes that satisfy hunger—make the nibbling habit work for you, not against you.

Taken daily, the two delicious Dietene milk-shakes provide over 50% of optimum adult requirements for protein, vitamins and minerals, yet only 380 calories. Dietene makes possible a wide variety of foods to eliminate monotony and help establish sound eating habits.

Particularly when obesity complicates an illness, you must have patient cooperation to insure weight reduction and sound nutrition.

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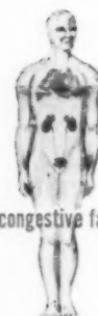
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**FREE 1 POUND CAN
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See how good it tastes!

in edema or

- more doctors are prescribing—
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in congestive failure



in hypertension



in premenstrual edema

"Chlorothiazide was given to 16 patients for a total of 295 patient-treatment days." "Chlorothiazide is a safe, oral diuretic with a clinical effect equal to or greater than a parenteral mercurial." Harvey, S. D. and DeGraff, A. C.: N. Y. State J. Med., 59:1769, (May 1) 1959.

DOSAGE: Edema—One or two 500 mg. tablets DIURIL once or twice a day. Hypertension—One 250 mg. tablet DIURIL twice a day to one 500 mg. tablet DIURIL three times a day.

"... our program has been one of polypharmacy in which we attempt to deplete body sodium with chlorothiazide. This drug is continued indefinitely as background medication for all antihypertensive drugs." Moyer, J. H.: Am. J. Cardiology, 3:199, (Feb.) 1959.

SUPPLIED: 250 mg. and 500 mg. scored tablets DIURIL (chlorothiazide) in bottles of 100 and 1,000. DIURIL is a trademark of Merck & Co., INC. Additional information is available to the physician on request.

"Chlorothiazide is an excellent agent for relief of swelling and breast soreness associated with the premenstrual tension syndrome, since all patients [50] with these complaints were completely relieved." Keyes, J. W. and Berlacher, F. J.: J.A.M.A., 169:109, (Jan. 10) 1959.

"One treated
"In the
tectable
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live ora
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hypertension

DIURIL®

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in edema of pregnancy



in cirrhosis with ascites



in renal edema

"One hundred patients were treated with oral chlorothiazide." "In the presence of clinically detectable edema, the agent was universally effective." "Chlorothiazide is at present the most effective oral diuretic in pregnancy." Landesman, R., Ollstein, R. N. and Quinton, E. J.: N. Y. State J. Med., 59:66, (Jan. 1) 1959.

"All three of the patients with Laennec's cirrhosis, ascites and edema had a favorable response, with a mean weight loss of 8 lbs., during the five-day treatment period with a slight decrease in edema." Castle, C. N., Conrad, J. K. and Hecht, H. H.: Arch. Int. Med., 103:415, (March) 1959.

"In a study of 10 patients with the nephrotic syndrome associated with various types of renal disease, orally administered chlorothiazide was a successful, and sometimes dramatic, diuretic agent." Burch, G. E. and White, M. A., Jr.: Arch. Int. Med., 103:369, (March) 1959.



MERCK SHARP & DOHME
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'HOW TO HANDLE THE 'CHISELER'



DR. ALAN EMANUEL, a New York City general practitioner, blames fly-by-night tax "consultants" for encouraging some patients to tax-deduct far more for medical expenses than they've really spent on such care.

Some choice examples of Group 1:

¶ From a California G.P.: "I was asked by the father of a newborn to antedate the delivery on an insurance report, so that it would be covered by a policy that had expired at the time of birth. I explained that the birth certificate had already been sent to the vital-statistics bureau and that the insurance company would check. I neither collected the bill nor kept the family as patients."

¶ From a G.P. in Minnesota:

"My patient had a health policy with a rider excluding asthma. I hospitalized her because of an acute asthmatic attack. She asked me to submit another diagnosis on the claim form. I submitted the truth. I've lost her as a patient."

¶ From a St. Louis radiologist: "One of my patients fractured her ankle as the result of a fall on her kitchen floor, and I did an X-ray that very day. The next day, she was in a minor bus accident. She asked me to change

Continued on page 334



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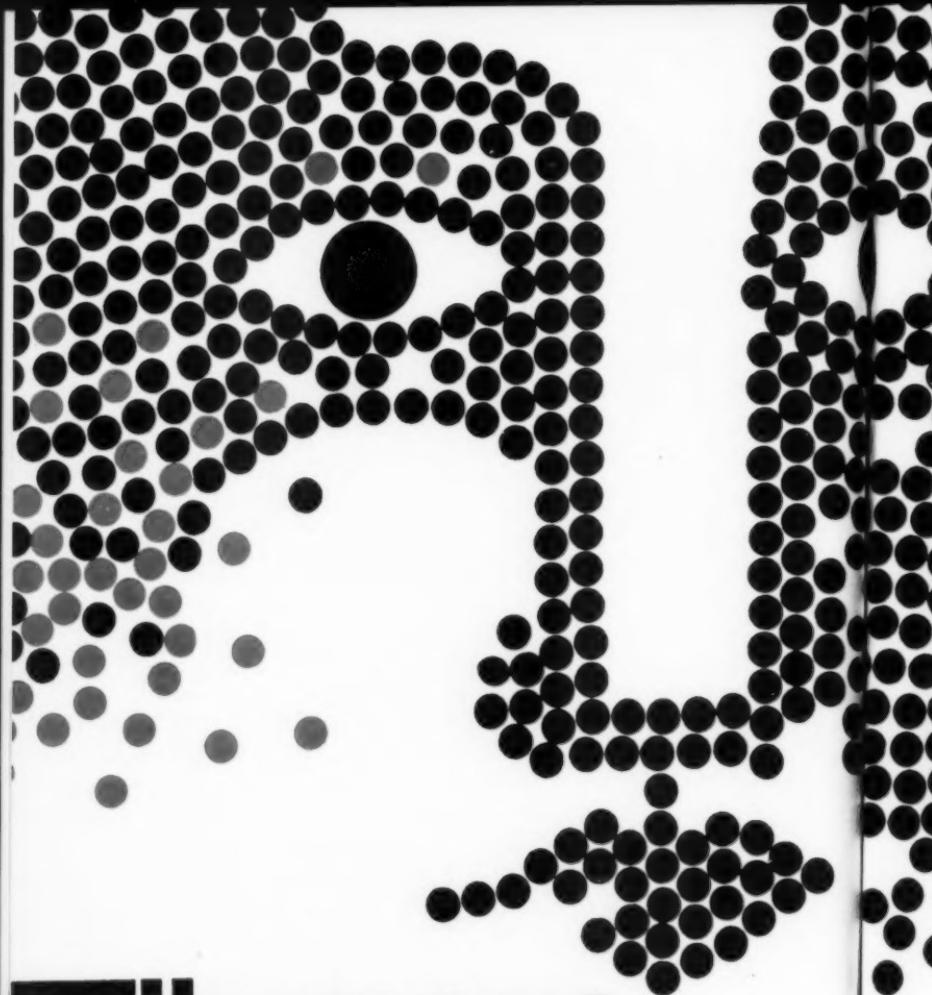
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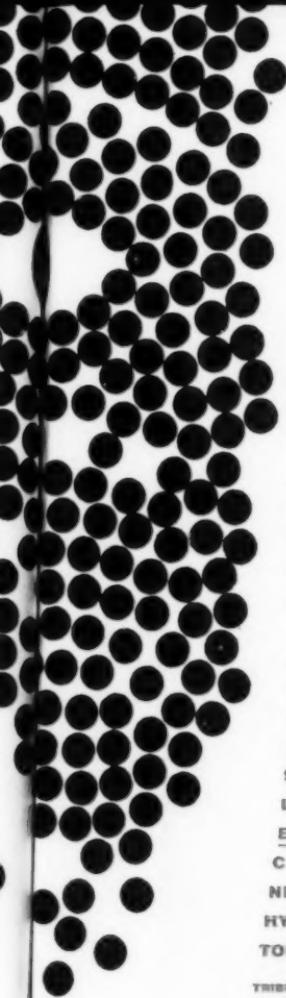
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REFERENCES: 1. R. J. SCHNITZER, E. GRUNBERG, W. F. DELORENZO AND R. E. BAGDON, *ANTIBIOTICS & CHEMOTHER.*, 9:267, 1959. 2. R. C. V. ROBINSON, *ANN. NEW YORK ACADE. SC.*, 82(ART. 1), 144, 1959. 3. E. EDELSON, E. GRUNBERG, A. D. CALARRESE AND T. V. MORTON, *IBID.*, P. 124. 4. P. L. WILLIAMS, *IBID.*, P. 135. 5. F. T. BECKER AND J. L. TUURA, *IBID.*, P. 131. 6. S. M. BLUEFORD, *IBID.*, P. 119.

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HOW TO HANDLE THE 'CHISELER'

the X-ray date so she could sue the transportation company for her fracture. When I refused to do so, she told me off in withering terms. I've never seen her since, and never been paid."

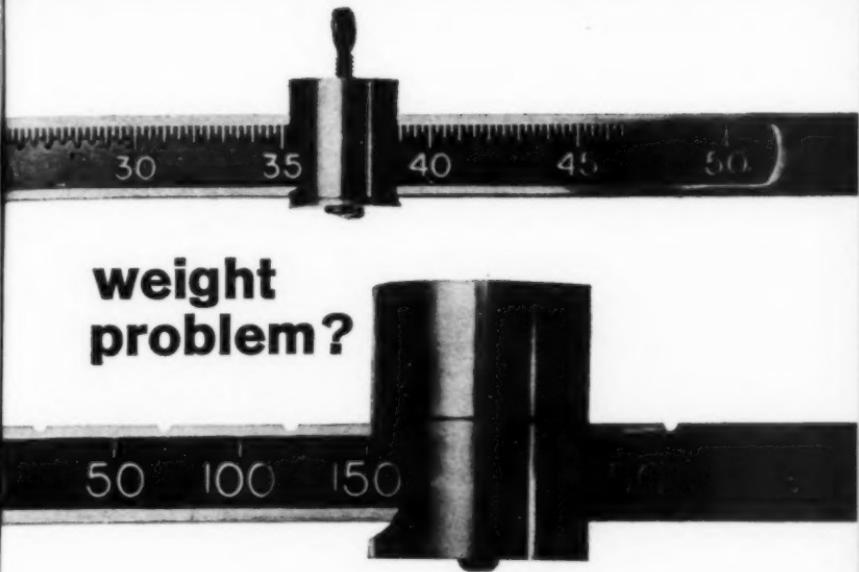
¶ From an ophthalmologist in Brooklyn, N. Y.: "An old patient of mine wanted a receipted bill for \$400 for income tax purposes. He had paid me \$10 during the year. I told him his falsified deduction would be checked against my tax return, and I'd be in the soup. My statement didn't impress him. He has never returned."

Chiselers of the second type—those who drag out symptoms in order to collect more money or to stay away from work longer—don't generally need to solicit the doctor's connivance. But when he becomes aware of their fakery and refuses to play along, they often feel personally affronted.

"I once treated a patient for a bruised arm," reports a G.P. in Baltimore. "He returned fifteen days later and asked me to sign a disability claim stating that the bruise had caused total disability of two weeks. There was no sign of the bruise—and he had just



DR. LELAND C. POMAINVILLE, a G.P. in Wisconsin Rapids, Wis., points out that if a doctor encourages a would-be chiseler once, "he'll be back for more favors."



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returned from fourteen days of hunting. So I refused to attest to more than two days' disability. I lost the patient."

And a Massachusetts gynecologist recalls: "When I was in general practice, many former servicemen with minor disabilities used to urge me to get their V.A. benefits extended or perpe-

tuated. In such cases, I did nothing to help their claims. And I usually lost them as patients."

But *need* you lose the patient whose deceptions you refuse to abet? Although most of the above comments seem to suggest so, a majority of the 250 surveyed physicians disagree. They maintain that a really tactful re-



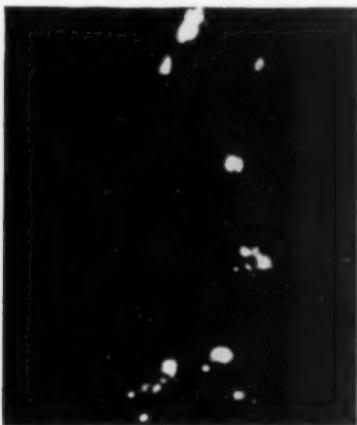
DR. HAROLD J. QUINN, a Quincy, Mass., G.P., says the few chiseling patients he's encountered have been prompted to it by "chiseling lawyers."

Clarin*

can do this for your postcoronary patients



WITHOUT CLARIN, turbid blood serum five hours after a fat meal: This unretouched dark-field photomicrograph (2500X) shows potentially hazardous fat concentrations circulating in the blood stream of a patient after a standard fat meal.

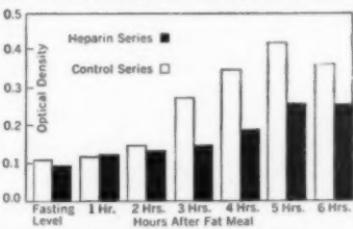


WITH CLARIN, clear blood serum five hours after a fat meal: After eating a standard fat meal as at left, the same patient has taken one sublingual Clarin tablet. Note marked clearing effect and reduction in massive fat concentrations in this unretouched photomicrograph (2500X).

CLARIN is sublingual heparin potassium. One mint-flavored tablet taken after each meal effectively "causes a marked clarification of postprandial lipemic serum."¹ Clarin facilitates the normal physiologic breakdown of fats, with no effects on the blood-clotting mechanism.¹ It therefore provides important benefits for your postcoronary patients.

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1. Fuller, H. L.: Angiology 9:311 (Oct.) 1958.
2. Shaftel, H. E., and Selman, D.: Angiology 10:131 (June) 1959.



Average serum optical density in 36 patients after fat meal with and without sublingual heparin.²

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HOW TO HANDLE THE 'CHISELER'

fusal, combined with a reasonable explanation, will not merely nip the unpalatable scheme in the bud; it will also satisfy the patient.

"I tell the would-be chiseler that insurance companies check up by personal investigations,"

says a New Yorker. "That's a point that makes sense to all but the undesirables."

Adds an Indiana man: "I explain as gently as possible that if I were willing to misrepresent for the patient, I'd probably be

Continued on page 342

Rx FOR HANDLING THE WOULD-BE CHISELER

Here are some points made by physicians who have found that tact and persuasion are usually the doctor's best weapons against the occasional patient's attempt to abuse his health coverage:

1. Don't assume the patient's guilt. He may have been booby-trapped by an insurance agent who promised more than the policy did. Or he may be suffering anxiety or fatigue, real symptoms that aren't "chiseling."
2. Don't directly accuse the patient of dishonesty. Instead, give him some logical reasons why the insurance company, hospital, or government agency will spot any discrepancies in your report.
3. Try not to sound too moral or sanctimonious. But make it clear that he can't expect to get away with false claims even if you should help—which you won't.
4. Point out that in good conscience you can't go along with the proposed deception, no matter how slight. Suggest that the patient put himself in your position; then ask how *he'd* feel about it.
5. If tact and persuasion don't work, show him that he's asking you to be a party to perjury and fraud.
6. Don't worry if honesty loses you such a patient. Remember, a person who's determined to cheat someone else will be just as determined to cheat you.

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1. Knox, S.C.: The nervous system never rests, Scientific Exhibit. A.P.A., Philadelphia (April 27-30) 1959.

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References: 1. Duvencel, J., et al.: Ann. Allergy 27:695, 1959. 2. Rudolph, J. A., and Rudolph, B. M.: Ann. Allergy 27:710, 1959. 3. Spies, T. D., et al.: South. M. J. 51:1066, 1958. 4. Galli, T., and Mannetti, C.: Minerva med. 50:949, 1959. 5. Segal, M. S., et al.: Ann. Allergy 27:413, 1959. 6. Bunim, J. J., et al.: Arthritis & Rheumatism 1:313, 1958. 7. Silverman, H. L., and Urdang, A.: Am. Prof. Pharm. 25:531, 1959.

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HOW TO HANDLE THE 'CHISELER'

willing to misrepresent to him as well. I find few patients who don't see the logic of this."

And a Washington State doctor apparently gets good results through a careful choice of words: "I speak of *ethics*, explaining that I simply can't do anything that isn't ethically correct. Because the word 'dishonest' antagonizes the patient, I always avoid it. This technique has lost me very few patients."

When to Go Along?

The borderline between honesty and dishonesty is sometimes blurred, of course. When a physician isn't sure whether a patient is trying to cheat, he may well give him the benefit of the doubt. The surveyed men agree that it isn't their responsibility to be *strait-laced* guardians of public morality.

An illuminating illustration of this point comes from a Michigan G.P. Says he:

"One of my patients—a 45-year-old man—is an inveterate duck hunter. For the past five years, just before the duck season, he has developed numerous

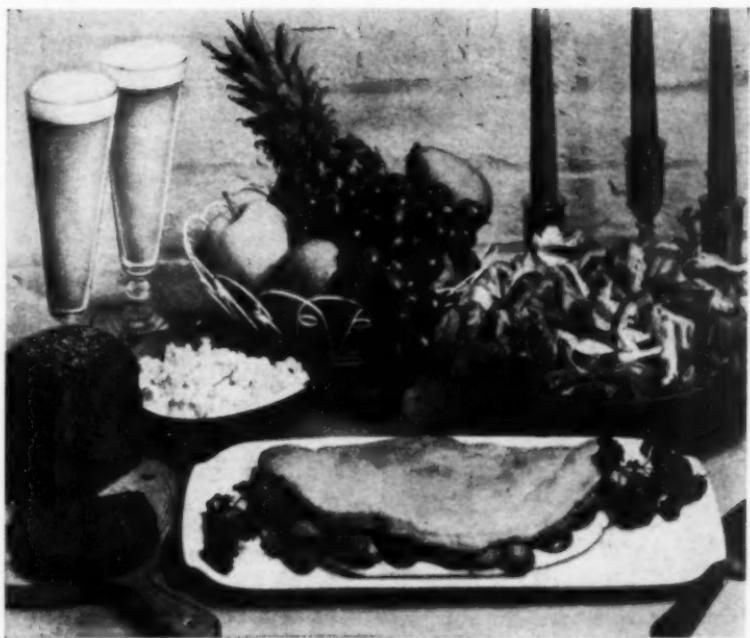
anti-social symptoms. He fights with his business associates, argues with his supervisors, and so on. His company then sends him to me for examination. There's nothing really wrong with the man physically; he just wants to go duck-hunting at company expense.

"But his mental condition is such that I feel justified in diagnosing a reaction of anxiety and in prescribing a short leave of absence. He gets his duck-hunting. The company gets a good man back in normal mental condition, and I keep a satisfied patient."

When it comes to *obvious* chiseling, though, five out of every six of the surveyed doctors state emphatically that it's the physician's duty to discourage all such wrongdoing.

'M.D. Should Be Concerned'

Is the policing job *primarily* his? Many of the surveyed men think so. "It's the complete responsibility of the doctor," says a Connecticut G.P. A Colorado surgeon says: "Ninety-five per cent of the physician's responsi-



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HOW TO HANDLE THE 'CHISELER'

bility." An Oklahoma orthopedist puts it at 75 per cent (with insurance companies and government agencies assuming the rest).

But a number of medical men don't entirely blame patients for yielding to temptation. After all, they point out, the behavior of the insurance people themselves is not always above reproach. Says a surgeon in Memphis, Tenn.:

These Men Disagree

"I've had chiseling patients, as most doctors have. But I've had even more patients who were chiseled by second-rate insurance companies that wouldn't pay a claim that should have been paid. Many of these instances were due to an overzealous insurance salesman's filling out the policy application and putting down 'no previous illness' without even asking the applicant."

The minority of doctors who believe they should *not* feel responsible for keeping their patients honest apparently agree with the Memphis man—only

more so. Says a Missouri internist: "The insurance company agent is too often the real culprit. Insurance agents tell too many people they'll have coverage that just isn't included in the policy. Why should doctors take the responsibility for this deceit?"

And a surgeon in a small New Jersey city raises a very different question: "As a group, we doctors are supposedly intelligent and honest men. So how can you expect us to police cheating patients when we know that some of our *colleagues* are equally dishonest?"

'Keep the Patient Honest'

To repeat, the survey has turned up very few such comments. It indicates, instead, that the vast majority of America's physicians share the opinion of a Chicago man who says: "A doctor should be absolutely honest with himself in dealing with the chiseling patient. He should do his best to keep the patient as honest as possible. If all doctors did both these things, we could put the word 'chiseling' back where it belongs—in carpentry." END

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1. Rose, E.: DaCosta Oration, Philadelphia County M. Soc., Oct. 10, 1956. 2. Kupperman, H.S.: Surg. Clin. North America, Apr. 1957, p. 517. 3. Kearns, J.E.: Quart. Bull. Northwestern Univ. M. School 31:97 (Summer) 1957. 4. Dyson, A., and Wood, M.W.W.: Lancet 2:757 (Oct. 13) 1956. 5. Finkler, R.: J. Am. M. Women's A. 14:593 (July) 1959. 6. Steinertz, K.: Klin. Wchnschr. 34:265 (Mar. 1) 1956. 7. Zondek, H., et al.: Acta endocrinol. 18:117 (Feb.) 1955. 8. Foster, H.M.: Am J. Obst. & Gynec. 77:130 (Jan.) 1959. 9. Council on Drugs of A.M.A.: J.A.M.A. 164:972 (June 29) 1957. 10. Newman, S., and Escamilla, R.F.: California Med. 88:206 (Mar.) 1958. 11. Frawley, T.F., et al.: J.A.M.A. 160:646 (Feb. 25) 1956. 12. Travell, J., et al.: 3rd Internat. Cong. of Rheumatic Diseases, Aix-les-Bains, France, June 29, 1956. 13. Helm, A.: Internat. Rec. Med. & Gen. Pract. Clin. 170:86 (Feb.) 1957. 14. Starr, P.: Spectrum 6:262 (May 15) 1958.

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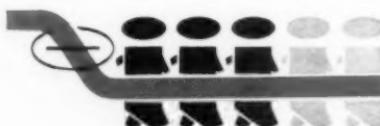
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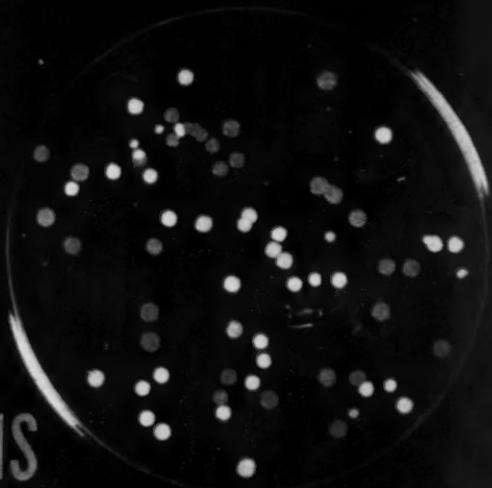
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1. Smith, I. M., and Soderstrom, W. H.: J. A. M. A., 170:184 (May 9), 1959.

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Memo

From the Editors

Hard Way Out

Doctors aren't the only ones who risk having their best work called malpractice. Editors and publishers risk it too. In their case, the alleged malpractice usually goes by the name of *libel*.

A libel claim may be made about any printed statement that injures someone's reputation. Suppose Senator X were described in these pages as "being paid to socialize the medical profession." Suppose Senator X decided that his reputation had thus been impaired. To ward off a libel judgment, we'd have to be able to prove (1) that the statement itself was demonstrably true, and (2) that we printed it without malice.

Faced with this formidable legal burden, some magazines duck it entirely. They print nothing at all controversial. That's the easy way out—but it's not MEDICAL ECONOMICS' way. Here's what we do instead:

When a controversial article is almost ready to run, we call in legal counsel. Under their direc-

tion, facts are weighed for legal validity; dubious statements are strengthened or deleted. Only after this screening is complete will you find the article in MEDICAL ECONOMICS.

Elsewhere in this issue, for example, you'll find "How 'Cheap' Health Insurance Can Rob You and Your Patients." It's based on much more ample documentation than could be included in the article. This extra evidence served no other purpose than to convince our attorneys that we should publish the piece.

In several recent issues, too, you've seen stories about a "nurses' registry" that had been selling memberships to doctors' aides. Extensive research went into these stories. Still, we couldn't say that this registry "creates the false impression [that it] is a nonprofit organization of professional nurses when it is purely and simply a money-making operation." But when the Federal Trade Commission finally said it, we could quote it and add important background.

Why do we bother with such articles? If they're bound to be troublesome, why not just forget them? The answer lies in our conviction that such stories are a real service to readers. They supply cold facts on hot subjects. Of such stuff are the best editorial menus made.

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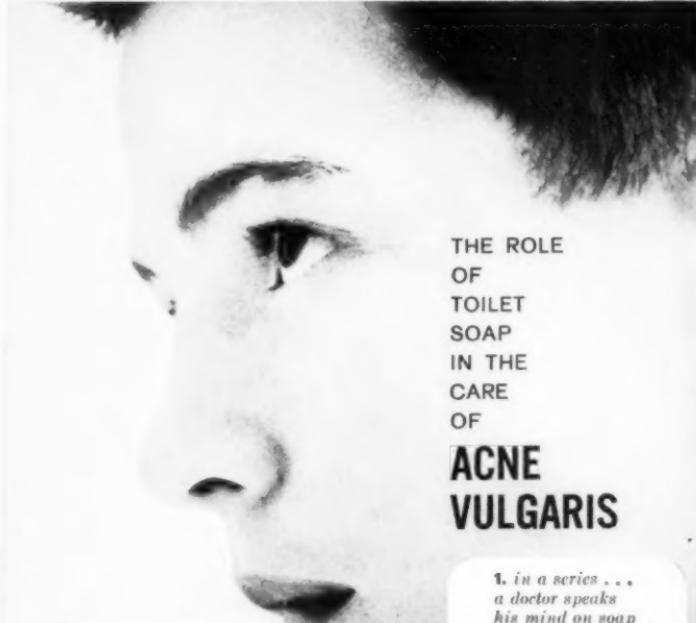
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DOWNING, JOHN GODWIN: Medical Clinics of North America, Vol. 39, No. 5, p. 1254 (September) 1955

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